THE
AMERICAN JOURNAL
OF
ORTHOPSYCHIATRY

A Journal of Human Behavior

THE OFFICIAL ORGAN OF
THE AMERICAN ORTHOPSYCHIATRIC
ASSOCIATION

EDITOR
Lawson G. Lowrey, M.D.

ASSOCIATE EDITORS
Herman Adler, M.D.
Augusta Bronner, Ph.D.
Porter R. Lee
Harvey Zorbaugh, Ph.D.

EDITORIAL ASSISTANT
Samuel J. Beck

VOLUME I

Copyright, 1931
by
The American Orthopsychiatric
Association

CONTENTS

VOLUME I OF THE AMERICAN JOURNAL OF ORTHOPSYCHIATRY

	Page
ALEXANDER, FRANZ: The training of the psychiatrist: Psychoanalysis in the education of psychiatrists	362
APPEL, KENNETH: Drawings by children as aids to personality studies	129
BARTEMEIER, LEO H.: The neurotic character as a new psychoanalytic concept	512
BECK, S. J.: Personality diagnosis by means of the Rorschach test	81
BECK, S. J.: The Rorschach test in problem children	501
BLANCHARD, PHYLLIS: The training of the psychiatrist: Training the psychiatrist in psychology	380
CONKLIN, AGNES M.: A study of the personalities of gifted students by means of the control group	178
DAVIS, ROSE and WILE, IRA S.: A comparative study of the Kohs block design test	89
FIELD, HENRY E.: The attitudes of prison inmates	487
FURFEY, PAUL HANLY: Case studies in developmental age	292
HAINES, ALICE R. and HOPKINS, CORNELIA D.: A study of one hundred problem children for whom foster care was advised	107
HARTWELL, SAMUEL W.: The treatment of behavior and personality problems in children: The psychiatrist	3
HEALY, WILLIAM: The training of the psychiatrist: Training in hospital and clinic	356
HOPKINS, CORNELIA D. and HAINES, ALICE R.: A study of one hundred problem children for whom foster care was advised	107
KASANIN, J. and VEO, LOUISE: The early recognition of mental diseases in children	406
LEVY, DAVID M.: Psychiatry and orthopsychiatry	239
LEVY, JOHN: A quantitative study of the relationship between basal metabolic rate and children's behavior problems	298
LEVY, JOHN: A quantitative study of the relationship between intelligence and economic status as factors in the etiology of children's behavior problems	152
MCLEAN, FRANKLIN C.: The training of the psychiatrist: A university department of psychiatry	345
MOULTON, BRYANT E.: Some causes of delinquency in relation to family attitudes	173
NEWELL, H. W.: Differences in personalities in the surviving pair of identical triplets	61
OLSON, WILLARD C.: Oral habits in children	311
PEARSON, GERALD H. J.: Some early factors in the formation of personality	284
PERKINS, NELLIE L.: Personality studies in a nursery school group: A critique of the Marston questionnaire	193
PRESTON, GEORGE H. and SHEPLER, WINIFRED MCLANE: A study of the problems of "normal" children	245
REGENSBURG, JEANETTE: Retraining in reading—a new method	163

226399

ROBB, CHRISTINE C.: Changing goals of psychiatric social work 476
ROSENOW, CURT: Orthopsychiatry and statistics 521
ROSENOW, CURT and WHYTE, ANNE H.: The ordinal position of problem children 430
ROWE, ALLAN W.: A possible endocrine factor in the behavior problems of the young 451
SCOVILLE, MILDRED C.: An inquiry into the status of psychiatric social work 145
SHEPLER, WINIFRED McLANE and PRESTON, GEORGE H.: A study of the problems of "normal" children 245
SULLIVAN, HARRY STACK: The training of the psychiatrist: Training of the general medical student in psychiatry 371
TAUSSIG, HELEN P.: Talks on mental hygiene to classes of grammar school children 184
THOMAS, CORONAL: The results of the Sims socio-economic rating scale when given to delinquent and non-delinquent juveniles 527
TOWLE, CHARLOTTE: The evaluation and management of marital situation in foster homes 271
TOWLE, CHARLOTTE: The treatment of behavior and personality problems in children: The social worker 21
TULCHIN, SIMON H.: Note on mental acceleration at adolescence and the related problem of mental age of adults 257
TULCHIN, SIMON H.: The treatment of behavior and personality problems in children: The psychologist 39
VEO, LOUISE and KASANIN, J.: The early recognition of mental diseases in children 406
WELLS, F. L.: Comparative psychology and mental hygiene 400
WHYTE, ANNE H. and ROSENOW, CURT: The ordinal position of problem children 430
WILE, IRA S. and DAVIS, ROSE: A comparative study of the Kohs block design test 89

EDITORIAL FOREWORD

THE original plan of the American Orthopsychiatric Association projected a Journal. Advice with respect to the possibilities varied considerably. It appeared that there were already too many journals flooding desks with material which people do not, after all, have time to read. In certain instances, space for the publication of papers and the proceedings was very kindly offered. However, the Association's officers have continued to feel that there is a very real place in American periodical literature for a journal devoting itself entirely to problems of human behavior, and accepting articles from any field which has a contribution to make which will aid in the understanding of such problems.

Accordingly, we herewith present the first issue, made up of a collection of papers read at the 7th Annual Meeting in February, 1930, in New York City. Successive issues will carry the other papers then given, as well as a few which have been read at previous meetings but not published.

In this number book reviews have been omitted, but that will be a regular section of later issues. The section entitled "Notes and Comments" is less for this issue than we should ordinarily hope to have, merely because the time for organizing this section has been very short and contributions are limited in number. Every member of the Association is urged to send in a pithy comment on any book read, and all possible contributions, long or short, to the section on "Notes and Comments."

Working out the details of the Journal has been a more gigantic task than was contemplated. It is, however, hoped that the quality of this and succeeding issues will more than justify the effort.

L.G.L.

THE AMERICAN JOURNAL OF ORTHOPSYCHIATRY

VOL. I OCTOBER, 1930 NO. 1

SYMPOSIUM: THE TREATMENT OF BEHAVIOR AND PERSONALITY PROBLEMS IN CHILDREN*

A. THE PSYCHIATRIST[1]

SAMUEL W. HARTWELL, M.D.
Director, Worcester Child Guidance Clinic, Worcester, Mass.

THE psychiatrist, the psychologist and the social worker are so closely associated in their attempts to alter undesirable behavior and personality traits of children, that it is not easy, even for discussion, to separate the function of each. And yet there is a very definite part of the general treatment of the problem child that belongs to the psychiatrist alone. He should have a deeper understanding of the responses and activities of the child's mind; he should be able to give a more accurate interpretation of them. He should have a more skilled technique for obtaining a knowledge of these activities, and he should have, above all, an ability to alter towards more normal and healthy trends, the mental responses of the child in so far as they may be altered by anything that may be said to him.

On the psychiatrist should rest the important and serious decision as to whether or not an attempt is to be made to establish a deep psychiatric rapport with the child, and whether or not the child is to be subjected to the profound experience of a deep mental exploration.

The understanding of the deep mental life of the individual is the foundation of all psychotherapy. This understanding is largely dependent on the amount of information obtained, and this in turn, is largely contingent on the depth of rapport estab-

* Conducted at the seventh annual meeting of the American Orthopsychiatric Association, February 22, 1930, New York City.

[1] To be included in a forthcoming book, (New York: Knopf).

lished between the patient and the one who is to understand and treat him. In child guidance clinic practice we must gain the large part of this information from what the child himself tells us. Analysis of behavior may help a little. Such things as the interpretation of his dreams may furnish some information. But even then the child is the only one who knows of *all* his behavior and he is the one who must report his dreams and his imaginative life. If he is *to be willing* to report these things correctly he must trust and respond to the one with whom he is talking. And if he is *to be able* to go deeply into his past and present mental experiences, and to tell freely and truthfully of them, a very positive response, rapport, transference, call it what you will, must exist between the child and the person who is to understand and help him.

This rapport serves not only as the instrument by which the necessary information may be obtained, and a true understanding reached, but it also serves that more important thing from a therapeutic standpoint, of lending constructive and dynamic force to what may be said to the child. I propose in this paper to discuss some of the concrete problems that present themselves to a psychiatrist as he sees, examines, and attempts to establish himself in the child's confidences.

The personal equation enters so largely into this important part of psychiatric technique that it is not easy to discuss or to describe one's methods or make one's ideas clear.

The intricate mental reactions that occur between two human beings when they enter one another's dynamic environment do not readily lend themselves to description. Much less is it possible to describe the essential things, or the technique, if one wishes to use the word, for obtaining and directing these responses in a way that will make them therapeutically useful.

Yet there are some concrete methods, things that one may try to do or may avoid doing, that *do* lend themselves to description. But, while considering these concrete methods, we must always keep in mind the fact that these things are *not* the essentials. Back of them all is that essential and potent something for which we are striving and which, for want of a better term, we may call "personality response."

It may be unwise for anyone to describe his methods in attempting to establish rapport with the child. The various ways

in which the idea is expressed shows clearly how differently it is understood by various people. Some say "getting the child's confidence"; some say "making the child like you"; some say "talking therapeutically with the child"; some say "getting under the child's skin"; some say "getting the child to be frank"; some say "getting an influence over the child," and some say "bringing the child to his senses." These phrases but show the great divergence of thought as to what actually happens between the child and the adult who attempts to help him.

Any plan or method of one's own developing is much more likely to be successful than one that he has borrowed from someone else. Everyone working with children knows the frequent failures that occur when he attempts to use others' methods of approach or of treatment.

These methods and ideas are discussed under various headings. They are not discussed in the order of their relative importance, but rather in the general order of their chronological appearance, as the child is seen, studied, and treated.

Being Sure That the Child Understands Who the Psychiatrist Is. This is important and should never be neglected. Before a child is asked to cooperate with the psychiatrist, even to the extent of the physical examination, he should be told in a way that he can understand, with whom he is talking and the reasons for the interview. Considerable time may have to be spent with the child to do this. We must dispel any suspicions he may have that the psychiatrist is a detective, or the individual who will control him, assign punishment or make a change in his environment.

If the psychiatrist puts himself in the child's place and thinks how the entire procedure appears to him, he can surmise what questions the child would like to ask. These things are, usually, the ones that may best be discussed first. For example, one of the first questions to which delinquent or misbehaving children will frequently respond, is whether or not it is best or easier to talk about one's troubles with the doctor, or with the policeman, or others who are in authority. This is something about which the child is thinking and about which he is apt to have ideas that he is willing to express.

The Physical Examination. Personally, I believe that it is much the best for the psychiatrist himself to make the routine

physical examination. I also believe that when the establishment of psychiatric rapport is important, or difficult to obtain, the physical examination should not be made until a friendly acquaintance has been reached. The examination itself presents many opportunities for the initiation of a good rapport and these opportunities may be lost in the process of a routine examination before the child feels acquainted.

The Child's Behavior During the Interview. One must be sure the child is physically comfortable during interviews. The child must not be hungry, ill, or in pain, and he should know where the toilet is. He should have a comfortable chair. The child must know that he will not be criticised or punished at home for being detained by the interview.

I prefer that the child sit still and look at me when we are talking, but I never scold him or try to make him do it. If he is hanging his head or speaking in a low or mumbled voice, he is seldom told not to do so but an earnest effort is made to remove the inhibitions that are causing this behavior. Going to lunch, attending a baseball game, or going for an automobile ride or a walk with the boy will often entirely change his manner in future interviews. I let him know, however without scolding him, what I think is proper concerning his general behavior in my presence, and elsewhere.

Making Notes in the Child's Presence. It is best to make notes immediately after the child has left, and especially before another child is seen. It is not usually advisable to take notes in the child's presence. Sometimes one may frankly write down just what the child says, as for example, when he tells of his dreams, but if it embarrasses him in any way one should not even do this. Essential details are not easily forgotten if one is really *thinking about* the child when one is talking with him. Even if they are, getting the details into the written record is secondary to the importance of establishing the desired rapport.

Knowing the Child's First Emotional Attitude towards the Psychiatrist. This is very important. The psychiatrist may know exactly what should be said to the child but if he says it while there is feeling of ridicule, dislike, a contempt, or fear of him in the child's mind, not only will he fail to help the child, but also he may find the child taking the same emotional attitude towards the things said that he has towards the one saying them.

A distracted mother once said to me: "I tell Willie over and over again that I don't see how he can be such a bad boy when his uncle John talks to him so much about being good and sets such a good example for him every day. I make Willie stay with him a lot, too, for his uncle John is such a good man and tells him so many times what he ought to do, that I am sure he will influence him somewhat, after a while."

It *was* hard to understand Willie and his bad behavior, all of which seemed to be without any drive or reason whatever, as far as we could judge from reports given of the boy. However, when Willie was given an opportunity to talk confidentially, he made the reason evident. He said he believed his uncle John was a "hypocrite and a snoop." Willie did not really want to be bad. He did not have temptation to do bad things, particularly. But he did want one thing very much, and that was not to be like his uncle John, or feel like him, and not to do anything his uncle John wanted him to do. With the emotional attitude Willie assumed towards his uncle, it would have been therapeutically better for the uncle to have told Willie to be a bad boy. Personally, when I am not able to get any positive rapport with the child, or if he is not at least neutral in his emotional attitude toward me and if he cannot be changed in this attitude by ordinary friendly association, such as may be had during the physical examination, I do not undertake even advice, let alone psychiatric exploration or psychotherapy.

Taking the Interview Seriously. Interviews should always be taken seriously, though one should never wear a long face when talking with children, and one should smile frequently. The child must not feel that he is considered unimportant or in the way. This is especially true of first interviews. It is unwise to allow interruptions to occur, or to permit one's self to be distracted by anything that does not directly concern the child. Usually each child, like the average adult, enjoys feeling that the doctor is especially interested in his particular case.

Using the Child's Vocabulary. Some children are so conditioned by their environment, or so limited in their ability to express themselves, that if they are to become entirely at ease and frank, they must use slang and vulgar expressions or even profane words and phrases to express their emotions and to make their meaning clear. The same thing, in a different way, may be true of the

spoiled child who has a tendency to talk in over-affectionate terms or to use "baby talk" when he becomes frank and friendly.

It is usually best not to discourage these things, especially at the beginning of the acquaintance; and often, if one can do so in an objective and unselfconscious way, it is well, at first, to adopt the same way of expressing one's self as that used by the child. This is a matter to be decided for each case, however, for if the child suspects that the psychiatrist is affecting this method of expression he will feel that the psychiatrist is doing it either to patronize him or to mock him, or for some other uncomplimentary reason and the child will think contemptuously of it. Of all the therapeutically negative emotional reactions the child may have, a feeling of contempt or of ridicule for anyone who is trying to help him operates most fatally against a good rapport and therapeutic results.

The use of vulgar or common expressions, in discussing sex matters with children is nearly always necessary and wise. Usually, if the child is in good rapport, he can be guided later into using more conventional terms although he starts with the common ones first. This is less embarrassing to the child than beginning with terms he does not understand and adopting the common ones later. This is a very important point in technique.

The Feeling of Being Understood. The most important single thing in obtaining a good psychiatric rapport with a child is to establish in him the belief and the feeling that the psychiatrist understands him. If a child is unhappy, if he is maladjusted, if his environment is such that he cannot possibly face it in a healthy way, the thing that will most often cause him to reach out and take someone into his life, is the belief that *that* person understands him. The statements and behavior of all the children I have known and helped tend to strengthen this opinion.

If a psychiatrist is sympathetic and appreciative before convincing the child that he understands him, the child is apt to feel that the psychiatrist is insincere and to classify him with others who have done the same thing and have failed to help him with his problems. To understand the child, not only must one know about his behavior and his emotional responses, but one must also be able to put one's self in the child's place, look at life through the child's eyes, and, for the moment, feel exactly as the child does about this whole living business. If one cannot

do this, one does not thoroughly understand the child and one probably cannot help him.

One must really understand the child before the child will believe that he is understood. Children are not easily deceived, especially in this respect. Very often, delinquent children who are unhappy because of their delinquency and what it has led to, have told, before the psychiatrist sees them, of their misdeeds. If they have reported their behavior to others who have in no way understood or been interested in how they feel, or how they felt at the time of their misbehavior, they have usually received little help. Most children who come to believe that the psychiatrist understands their present emotional responses will cooperate in his attempts to understand him further and deeper. They will, themselves, become interested in the dynamisms conditioning their behavior.

Getting the Child to Tell the Truth. This is the thing that many consider the most important of all. Diagnostically and socially, it is often essential. My personal experience is that if a child tells his real story for any other reason than because he wants me to understand him, much of the therapeutic value of the telling is lost. In this case, the story may be true and complete in its behavior details, but it is probably lacking in its emotional ones. After all, the therapeutic question is *why* and not *what*. Speaking therapeutically, the depth of the child's confidence should always depend upon the depth of rapport established.

If, a child who has become entirely frank with me is not glad of it, I have been a good detective but I certainly have not established a good therapeutic rapport. Since freely reporting his behavior and responses carries an emotional value for him, it follows that it is usually unwise from a therapeutic standpoint to encourage or to allow a child who is not in good rapport to tell his story. No one believes more in the constructive value of the "confession," or the "getting it off the chest," or whatever else it may be called, than the speaker; but the therapeutic value of this is largely measured by the circumstances of the telling by the reasons for the telling, and by the child's attitude toward the person to whom it is told, rather than by what is told. Children who have understanding parents with whom they are willingly and entirely frank seldom become problem children. When a child willingly gives me his full confidence because he thinks

I understand him and can help him, he has placed a great responsibility on me. If I have encouraged him to do this without really believing that in some way I can constructively assist him, I may have harmed rather than helped him.

Often in clinics, in cases in which a child may be seen but once or twice, the only probability of his receiving personality help is through the therapeutic value of the confession. Possibly, one may occasionally be justified in establishing a deep rapport with an unhappy child so that he will tell his real story for this reason alone. But the element of trust always enters into any good rapport, and the child, consciously or unconsciously, is expecting help. When nothing further in the way of social or psychotherapeutic help can be given, to cut him adrift in a sea of troubles and difficulties when he believes that at last he has found an understanding, helpful friend may add profoundly to his emotional troubles.

Making the Child Talk about Unpleasant Things. The ideal way is to make him feel like talking about serious and unpleasant topics, not to force him to do so, against his will. This is an easy prescription to write but it is sometimes very hard to fill. With unlimited time it may be done in any case in which good rapport is established. One can, at least, be sure that the child understands why he is being asked to discuss things he wishes to avoid and to forget.

Methods of getting uncommunicative and unresponsive children to talk willingly are so individual and so dependent on the interacting of personalities that attempts to describe them are futile. But a psychiatrist must have the ability to make children thus respond to him, if he is to help them.

Scolding or Criticising the Child. One should not scold or directly criticise the child. This very old form of psychotherapy is not entirely valueless, for it does work sometimes. When it does, it is because the one who has administered it has previously established a good and usually long continued rapport with the one who is scolded or criticised. By the time most cases are seen by psychiatrists scolding and criticism have already been tried. It often happens that the habit of withdrawing from those who administer this type of treatment is already so firmly established, that it is apt to be repeated with the psychiatrist. The psychiatrist must wait then until late in his contact with the child before

he tries scolding. But that time he will probably understand the child so well that he will feel no inclinations to scold or to criticise him.

Personally, however, to all children who have made good rapport and have developed any feelings of loyalty toward me or any desire that I should like or approve their conduct, I always make it clear just how I feel in an abstract way about behavior such as theirs. I wait for a favorable time to do this, and I do not over-emphasize its importance.

Being Disgusted or Shocked with the Child. A child should never feel that the psychiatrist is disgusted or shocked, either by anything he may tell or by anything he may have done. One who understands and likes children seldom experiences these emotional responses towards them. If a child tells me of things he has done or emotions he has experienced which I know have, for all time, destroyed for him, those fine indefinite things we call innocent childhood and happy youth, I am profoundly sorry for him but it requires no effort to avoid any feeling of disgust or repulsion.

I have had little success in trying to deceive children in regard to anything and I am skeptical of the ability of others to do so. But, if one is repelled by the child's behavior, one should deceive the child to the point of concealing this repulsion. This is particularly true if one is attempting to give the child help. It frequently happens that the child's knowledge that he has disgusted the one to whom he has been confidential, means irrevocable failure, as far as that person's helping him is concerned. These emotional reactions on the part of any adult who has established positive rapport are unfortunate when they are real and uncontrollable. They are always to be condemned when they are feigned. Many people, including parents, sometimes pretend to be disgusted and shocked when they really are not. I have known fathers who, in their sons' presence, appear greatly shocked and grieved by their behavior, but who later tell me privately that they themselves did the same things when they were young, and that they think their sons will be, after all, the better and wiser for their experiences. This is an attitude fraught with danger, especially for younger children who have voluntarily become confidential.

When a child becomes thoroughly confidential, there is some

strong emotional reason for it. To have a parent or respected person show a child that he feels disgusted or shocked at the child's confessed behavior, or to have him give the child the idea that his life or character has been permanently damaged, or that something has happened that has destroyed any of the former friendly relationship or love existing between the two, is one of the most profound psychic traumas possible for any child to experience. In one short hour all the confidences of the child's life may be destroyed beyond hopes of rebuilding, and when this thing happens between a child and his parents, or between a child and a trusted psychiatrist, the child is very apt to become distrustful of all the world. An experience like this may be the beginning of the child's resisting his environment or of shutting himself away from it.

After all, when most of us think about the regrettable, "wickedest" things in our lives, we arrive by some mental mechanism at the belief that in our particular case they were not so bad or disgusting. Were our friends to learn of them in some way, especially were we to confess these things to them, we would not expect them to feel much differently than we ourselves do. This is particularly so with children, who have not yet developed their moral apperceptions to that standard which most adults hope their children believe they, as their parents, possess and exemplify.

I have been told that I "sided" with the child or had a bad influence on him because of my refusal to scold or to condemn him or to be greatly upset about his behavior. Suppose a child does have his first friendly relationships with me on this basis? I still have a chance to do him some good, perhaps, really to show him how much I think bad behavior detracts from his happiness and from that of others, but if I adopt the opposite plan of scolding from the start, the child builds a barrier against me in his mind that destroys my opportunity of ever doing so.

Not so very long ago a man brought his thirteen year old son to me. In spite of my efforts to avoid it, he insisted on describing in detail, in the boy's presence, some very unfortunate habits, and delinquency that accompanied them, into which the child had been drawn. It was quite evident that the father expected me to be greatly upset when he told me these things and to display this state of mind to the lad. He said he had brought the boy to me to get my advice as to what type of punishment he might give

that would be severe enough sufficiently to punish the boy and at the same time to correct the behavior, without bringing any disgrace to the family. I answered, not by suggesting any punishment but by trying to make him see that he should take a different attitude toward the boy. I was sorry for this afterwards because it, apparently, had lost for me my only chance of attempting to help the lad, who needed help badly. The father said something about men who were dealing with bad boys becoming calloused and took the boy away without my having opportunity actually to talk with him. The boy had been talking to me with his eyes during the entire interview. The next day the lad came back to me without his parent's knowledge. I did not believe then, nor did later developments show, that he came back to me because he thought I would "side with him" in his misbehavior.

After talking to him a little while about his mother, it was decided with his permission to call her by telephone and tell her of the circumstances. She gave her sanction to this interview and to later ones. It was possible to give this boy help which, I think, will be of lifelong value to him. No one had to make him stop his bad habits. When he understood himself and his habits, what they meant and what they would lead to, he wanted to stop them and he did. More important than this, he came to understand his father better and to take a much better attitude toward him. Perhaps a mistake was made in not deceiving the father in regard to my own attitude in the first interview (he would have been very easily deceived), so that I might have been sure of an opportunity to help the lad, but I do not like to be a hypocrite before a child.

Respecting the Child's Confidence. If a child assumes, as he often does, or is assured that the things he tells the psychiatrist will not be repeated, this confidence should invariably be respected. If a child is in good rapport with him, the psychiatrist will seldom fail finally to obtain the child's consent and cooperation in reporting anything he may tell the psychiatrist, if this is necessary advice. If the rapport is not good, the psychiatrist will fail in this effort. This is one of the important reasons why confidences and confessions should not be encouraged or even allowed in superficial or negative degrees of rapport.

No matter who is responsible for the interview, the child is the

psychiatrist's patient, and the psychiatrist, as his physician, is highly privileged as well as duty bound to keep the secrets of his patient. The writer's personal experience has been that in no cases, good has resulted, either for the child or for society from breaking confidence with the child and reporting any part of the child's story given him in confidence without his consent. The child is uncooperative in any social treatment based on such information and society gains another suspicious and anti-social member, and the psychiatrist loses his chance of helping the child.

It is a dangerous thing for one who works with children, whether he be psychiatrist, judge, social worker, psychologist or probation officer, to take pride in getting the child's confidence in any other way than by making the child want to give it, and for any other reason than that he may give the child help. If it is essential that information in the child's possession be obtained from him for social reasons, only, the psychiatrist is not the one to get it.

The child's knowledge that his confidence is to be respected is a powerful therapeutic weapon, although it may easily be abused.

Answering the Child's Questions. One should truthfully answer all the child's questions with as much completeness as the child is capable of absorbing and of comprehending. Often, this is not possible at the time they are first asked, but they should not be forgotten, finally they should be answered. Asking questions is so important, therapeutically, that one should not discourage it by answering with lies. Of course, it is often not best to tell him immediately all the facts one may know about the things he asks, either about himself or his environment, but every question should be met at first with a truthful attitude. One should aim ultimately to answer frankly and truthfully.

Since this is a question much thought about and much discussed by all who are thinking and working with children, I shall report an example of what I consider a truthful answer to a question obviously hard to meet. It was asked me by a fourteen year old girl of superior intelligence who was failing in her school work. I knew from her family history and from seeing her mother what the answer to the question was. I, also, felt that from a therapeutic standpoint the girl must ask this question if I was to help her. Finally, one day she said to me, "Do you suppose that the things the girls have been whispering about my mother

are true?" She told me that she had observed things that made her fear they were.

This girl was very loyal to her young widowed mother who was in most respects an excellent mother and loyal to the child. I did not answer the girl's question that day, I suppose that technically I lied to her. During our next talks we discussed people who did not have good surroundings and training when they were children, people who have very strong temptations in the face of unhappiness, and especially those people who do things they would not otherwise do because of a desire in some way to help those they love. We discussed the fact that, after all, the reasons back of things are more important than the things themselves. We talked also about girls who could not pass in school because their minds were busy with worry and unhappiness, we discussed the fact that sometimes buckling down and trying to help others to be happy was the best way to get passing grades. When I believed the time had come for the answer to her question, I told her what I call the therapeutic truth. I told her that I thought the best thing would be for her to assume that the things she had heard about her mother were true, and that by being loyal to her mother, despite them, she might help her. I told her that some day, when she understood her mother and life better, she might discover that they were not true at all and, that whether they were facts or not, the mother was her mother and loved her and needed her. I told her that anyone who understood would admire very much a girl who could be so fine as this. In its final outcome, this case represented one of the best psychiatric successes the speaker has ever had. It illustrates very well two points, namely, that asking questions is a most hopeful and helpful symptom, and that a person in good rapport answering them is our best psychotherapeutic weapon. When this intelligent girl first asked me the question, I might have lied and said, "Why, whoever put such an idea into your head? Of course it isn't true. Now, you go home and study your lessons instead of thinking about such terrible things and you will be all right." Or I might have told the naked truth and said, "Oh, you poor girl. I am so sorry for you. Yes, I am afraid it is true. You will just have to make the best of it. There is nothing you or I can do about it. We have to admit the truth, even though it hurts." Either of these answers would have been therapeutically false.

Causing Discouragement, Fear, or Worry. Of those who are sincerely attempting to help children, very few believe that any of these emotions are ever desirable, but unless one thinks of the world and understands it the way the child does, one may very easily prompt these emotions.

There are many ways this may happen. Serious looks or gestures, or ambiguous remarks made during a physical examination may do it. Gaining the child's confidential story in regard to his sex habits, but at the same time, failing to help him understand and properly to interpret his feelings and experiences, very frequently causes much worry and even fear. Another and more dangerous thing is to suggest or elaborate psychopathical theories to a child who is already concerned about himself, or to ask unusual and vague questions which the child does not understand, especially if the child is in good rapport with the one asking them. These things often cause serious mental conflicts. If delicate questions are asked, explanations should be made so that he understands the reasons for the questions.

A case that well illustrates this point once came to my notice. Though he knew but little of psychiatry, a judge felt, that a certain boy whom he had sentenced to a correctional institution, should be given some sort of help that the institution could not give. He asked a psychiatrist who had thought but little about children's problems, to see this fifteen year old boy. The psychiatrist read the boy's history and the social worker's report, and before seeing the boy made the statement that he was "clearly a case of 'Oedipus Complex.' I think I can straighten him out." He saw the boy for forty-five minutes. In that time he elaborated to him the theory in its entirety, imparted a huge amount of bizarre theoretical psychopathical sex information, and told the boy that if he could remember what had been told him, that he would be all right and would turn out fine. In fact, he had so much to tell him that the boy himself had no opportunity or inclination to tell the psychiatrist anything. The boy went to the institution, the psychiatrist to his practice. He does not know the rest of the story to this day. In a few days the boy made an unsuccessful attempt at suicide. He was then studied at greater length, and after the study it was felt that the first psychiatrist was crudely correct in his interpretation. However, the practical situation was this. The boy got into trouble because he had no

friends. He had no friends because of his unhappy personality traits. His unhappy personality traits were due to a distorted outlook on life. His distorted outlook on life was caused probably by the unfortunate way in which he had handled his early emotional responses to his parent situation. The boy stated frankly the reason for wanting to kill himself. When he learned that his trouble was caused by being "so rotten and good-for-nothing inside," he thought suicide was the best solution. The psychiatrist who first saw him, knowing that his association with the lad would be brief, should have spent the time available in listening to the boy's story and convincing him, if possible, that there was at least one person in the world who could be interested in him and be his friend without being disgusted with him. Unless one has established a good rapport, it is not desirable to attempt to *think with* the child on a theoretical basis. For it is not so much *what* one says to the child that accomplishes therapeutic results as who says, and *the way* he says these things, and how they make the child feel.

Ridiculing or Shaming the Child. One should never under any circumstances use ridicule or try to shame the child or laugh at him. Because of this unfortunate method of dealing with them, children will often absolutely and unchangeably put out of their lives people who might otherwise be a great help to them. In *thinking with* children, I always try to get the child's own answer to the question *why*, as it applies to his emotional responses or to his behavior patterns. One question I very frequently ask is "Why do you so cordially hate your teacher?" The answer in more than half the cases is "Because she makes fun of what I do in front of the others." If this is not the answer, it often is, "Because she is not fair." This reply is given not nearly as bitterly as the first. Another question I frequently ask is, "Why have you failed to talk with your father and mother about these things with which you have needed help so badly?" And many of the children answer, "I'm afraid they wouldn't understand and would only laugh at me." What makes it seem worse to the child is the fear that many others will learn the joke and laugh at him, too.

Interest in a Child's Activity. The expression of interest in and knowledge of the things in which a child is interested is a very common, useful, and important way of establishing one's self in

the child's mental environment. A child will more quickly ask questions of his new friend if contact is established in this way. But he will also evaluate one's ability to answer other questions by the answers to these. One should be very careful about trying to make a child believe that one knows much about his world and interests unless one really does.

At one time I was interested to know why a certain scoutmaster, whom I knew and believed had the personality traits for a good and successful boys' worker, was very unsuccessful in his personal contacts with boys. I discovered that the scouts were contemptuous of him. As one boy said, "He pretends to know all about everything anybody talks about, and I don't believe he ever went on a real camping trip or played a ball game in his life, from the way he goes at it." The scoutmaster would have made much better contact with his boys and gained their respect more quickly by confessing his ignorance and by expressing a desire to learn. Every child is glad to show and to tell about things he knows or things in which he is interested, particularly to anyone who is really sincere and wants to be informed. I have often seen a spoiled or a frightened child who would not talk to me, become friendly in the process of explaining t me some mechanical toy which I had failed to operate. A psychiatrist should develop a sincere interest in children's activities, both because it will help him in the understanding of the child and because it will keep him young. Anyone in this day and age who is able to talk intelligently and answer the average twelve year old American boy's questions about aeroplane and radio construction and operation has no mean accomplishment, and he will gain much in the boy's estimation by this ability.

Keeping Appointments and Promises. The experience of many years in Boy Scout work, during which I have asked hundreds of boys why they did or did not like their leaders, has taught me that promptness and faithfulness in keeping appointments and promises is one of the most, if not *the* most important concrete thing one can *do* to obtain a child's liking and respect. Broken or neglected appointments are the forerunners of failures to help unhappy children. Vague appointments or vague promises of excursions or recreational activities should never be given to a child. It is much better to say once during the period of acquaintance, "Next Thursday, after school, I will come to your

home and we will drive down to the beach," and then really to keep that appointment, than to say at the close of every interview, "We must take a little trip some day," and never do it. In dealing with children, poor excuses are not better than none. Breaking an appointment for an interview is dangerous business, for a child may have been looking forward to keeping it and he may have decided that at that time he will tell or discuss things of serious importance to him. If the appointment is broken, his reasoning is apt to be this: "Well, he doesn't understand me, that's all. He asked me to come, and if he knew how much it meant to me, he would not have forgotten and had another boy come at the same time and then send me away. I thought he did really know how I felt and came very near being fool enough to tell him those things. Nobody really cares for me anyway."

Maintaining Friendly Relations. Finally, one should never quarrel or argue with the child and one should always try to part from him as a friend. If one has failed with him one can usually understand the failure by looking at the world through the child's eyes. A good understanding of a child with whom one has failed fortunately destroys the desire to give the child a final "piece of one's mind" and prevents the disastrous effects of such finales. Parting sharpness on the part of the psychiatrist not only nullifies any good that may have been accomplished but also interferes with the possibility of anyone else giving the child help.

When the therapeutic contact is finally closed, the child should always be made to feel that the psychiatrist is still his friend and that he is eager to help with any problem that may arise later. Children with whom a good rapport has been established will very frequently wish to return to the psychiatrist for help at a much later date.

Perhaps some will feel that I have not been talking about treatment at all; but it seems to me that all of us, both children and adults, are largely what we are because those who have entered our dynamic environment, either positively or negatively, have shown us by precept and example how they have interpreted and responded to life's situations. Surrounding us at all times have been many others who may have given us better precepts, and may have shown us better examples than those we have consciously or unconsciously followed. Our intellectual habits,

our behavior patterns, and our personality traits, established largely in childhood, have been determined not by what was said to or done before us, but by *who* said or *who* did the various things.

A knowledge of the principles of mental hygiene, an understanding of the mental dynamisms of all life's adjustments, the evaluation of a child's environment and experiences, and a knowledge of how best to interpret these things to our young patients are essentials of psychotherapy. But that indescribable but very definite thing, the inter-response between two human minds and personalities—call it what you will—is after all the thing and the only thing that makes our therapeusis dynamic and useful.

B. THE SOCIAL WORKER

CHARLOTTE TOWLE
Institute for Child Guidance, New York City

IT IS generally agreed that treatment starts with the first contact. Hence the social worker should have a dynamic relationship with the family from the start and does have if she makes a meaningful social examination. Then the social examination is not a still life painting, depicted by a detached observer, but a scene of human action the portrayal of which has involved not only the ingenuity of the artist but the prolonged cooperation of the subjects. The very fact that we have developed our study techniques has brought through vital history material, of a nature requiring skill in treatment at an early stage, if we are not to lose the rapport of the individuals concerned. A mother may, in response to the ingenious method of the worker, reveal the intimate problems of her married life, but after the departure of the worker, may lose the security afforded in her emotional transference to the worker, and so may develop a conflict. If this conflict is not anticipated and thoughtfully handled by the worker, the mother's reaction may prove a decided block in treatment. In fact, in our emphasis on thorough investigation, this has occurred to such a degree in many cases that some experienced workers are advocating a more gradual securing of history material —with treatment tentatively planned and cautiously administered in the light of what the history reveals in each phase of its evolution.

Before analyzing treatment technique it would be well to consider the nature of the worker-patient relationship. The individual being served by a social organization has invariably turned to that organization for help on some problem or group of related problems—whether it be relief, the placement of a child, the adjustment of marriage difficulties, guidance in the behavior difficulties of Johnnie, or a combination of any or all of these factors. The basic need of the individuals concerned is guidance and so they turn to the individual, who represents the organization—because he is considered or felt to be, at least for the time being, better qualified or more adequate to deal with the situation than they themselves are. This seeking of adequacy in another tends to

recreate the parent-child relationship. The organization, if it functions constructively, must therefore be a source of parental security. Furthermore, it should guide and actually help without fostering undue dependency—with a view to releasing the dependent individuals as soon as they can function unaided.

The worker representing the organization, must, therefore, play in accordance with the needs of a case—a mother or father rôle. The effective accomplishment of this involves a close identification with the individuals concerned, a very personal sort of relationship in which, however, she must remain sufficiently detached emotionally to not become the patient. The problems must remain the patient's and not become hers if she is to maintain her adequacy in the situation. A bit of technique in safeguarding this situation lies in keeping the presence of the organization in the picture, for this offers a greater security than any one individual can give through injecting an element of permanence to tide over shifts in personnel. Furthermore, it is an aid at the time of transference of the patient onto his own, for it relieves his need to clutch at the worker as at a personal identity, who once relinquished may be lost forever. At such a time the patient can gain security from the thought that the organization, with others to help, will be there permanently to serve in a time of need. Instead of fostering dependency this frequently stabilizes the patient through minimizing the sense of personal loss.

Granting that this worker-patient relationship is essentially a parent-child one, it is therefore in the life histories of the individuals concerned that the clues to the handling of treatment lie. In this connection the early parental relationships of each individual are particularly significant. In dealing with any individual, the worker needs to consider, what was there in the parental handling of this person that was particularly constructive that she may now employ—what was there that was highly destructive that she should avoid recreating in the present situation. For example:

James A, a boy of 11 years, had been referred because of stammering. A study of the case revealed an over-authoritative father who tended not only to play the rôle of a dominant father but who also tended to crowd the mother into the background, thus both fathering and mothering the family, including his wife. The patient was not only under the strain of constant criticism for his speech but was over-supervised in practically every aspect of his life: he

must do good work in school; his reading must be approved by his father and any book questioned because of subject matter or poor literary style must be taken away from him; his companions like-wise underwent paternal scrutiny with frequent objections; his sex habits were watched and although he had not been known to masturbate, he was frequently observed at night to be sure he was not practicing this habit; his table manners were subject to frequent corrections with much nagging for eating too fast. Thus the boy was under the tension of strict supervision by day and by night. An interesting point confirming the opinion that tension in relation to the father was significant lay in the fact that while at home his stammering was extreme and considered a major problem, at school it was so slight as to be almost negligible and did not interfere with his academic or social adjustment. The boy's mother in an effort to offset the father's strictness had tended to play an over-protective rôle, thus causing some regressive infantile trends which interfered with his ego development, thus probably rendering him even less able to stand up under the paternal domination.

The father's life revealed a dominant mother, an easy-going somewhat inadequate father. As a child he was physically puny; during adolescence he definitely set out to overcome his physical inadequacy and took much pride in stating that by the time he reached college he had himself in shape for the football team. On the basis of his ambitious mother's drive, he worked his way through college, later taught school for years and is now a successful business man. He takes pride in being "self made" and now is puzzled over the frustration which he is meeting in trying to mould his son. He evidences admiration of his mother whom he has apparently accepted and with whom he seems to be identified. Toward his father he has a kindly attitude, but does not evidence the same high regard as toward the mother.

In dealing with this family the organization has from the start endeavored to identify with the dominant mother in regard to the father and to play the rôle of the understanding tolerant parent with the dependent mother and patient. The work is going somewhat as follows.

The father being gravely concerned over his son because of his ego involvement at having an unadjusted boy with whom he is unable to cope, is definitely seeking help from the Clinic. "I will do anything you recommend" were his words and yet in the first interview with the psychiatrist he had a dominating, irritable attitude with a tendency to tell the psychiatrist what was wrong with the youngster and how he ought to be managed. Sensing that an indirect approach would tend to put the organization under his domination, and being mindful of his early parental relationship—the psychiatrist made a very direct approach, explaining the problem of emotional tension due to paternal oversupervision and placing the responsibility directly on the father's

shoulders he pointed out what he must and must not do if any headway is to be made in the treatment of patient. This was an essentially negative approach, one which is infrequently used but which in this case immediately broke the ice, for the father responded by discussing his own boyhood problems, by confessing to undue strictness with the patient, by admitting his great drive for the boy to succeed and his bewilderment over his failure in handling him successfully. In short he became the dependent son—seeking advice, saying "What shall I do, Doctor?" Recognizing that while this approach had been effective it had necessarily involved an ego injury which might lead to irritation with the projection of same onto the family on the basis of an increased compensatory drive, the psychiatrist tried to offset this negative entrée with an ego appeal, by emphasizing the patient's need for him, the high potentialities of patient who is intelligent like his father and the contribution which so intelligent and successful a father can make to a son. The social worker in supplementing the work of the psychiatrist will aim to identify herself with him in the ego approach, making constructive suggestions as to what can be done for patient. Her contact will be essentially positive—in order to build an ego satisfaction—to offset the temporarily destructive but potentially constructive effects of the negative aspects of treatment in this instance.

The social worker in carrying the treatment with the mother has tried to be the understanding parent. Because of her great dependence on the father the mother has been quite protective, giving her confidences slowly, but showing her need for advice as well as a cooperative attitude toward following same. She has responded to suggestions as to releasing the boy. She admits the boy's need for a more understanding father and seems ready to encourage a better relationship between them. Because of the unquestioned leadership of the father, it is felt that her response to a change in his attitude is assured.

With the patient both psychiatrist and worker are being understanding and tolerant parent persons. The psychiatrist is gradually relieving the boy through psycho-therapy. In giving the patient a constructive father relationship in himself, as well as through giving him some point of view about his own father, he is preparing him for a gradual shift to the own father as the latter gradually through a changed attitude accepts the boy.

In carrying treatment with the mother who seems to be a dependent individual on the basis of an early dependency on her own mother, the social worker will try to contribute to her security through keeping her in touch with the changing attitudes and needs of the father and patient. She will, through giving the mother understanding of why the father has such a need to be strict with patient—since the difference over the handling of the patient seems to be the major precarious element in this marital situation—try to create a more sympathetic attitude on the part of the mother toward the father's attitudes, with view to arousing a constructive response to any changes on the father's part. Her objective with the mother will be to throw her even more over to the father so that with a gain in emotional security in the father, she will have less need to turn to the patient for satisfaction in over-protecting him and so will probably not be so threatened by treatment suggestions to the effect that she let him "grow up."

Although the psychiatrist is playing the major rôle with the patient as well as temporarily with the father, the social worker is supplementing his work with both individuals and will gradually treat the father. She is carrying the mother, as well as acting in *liaison* capacity for the three. She has therefore the need of being identified with the psychiatrist which means that she is not only aware of the behavior mechanisms operating throughout the situation, but will have to guide the family in any situations that arise, in accordance with their parental needs.

While only a bare start has been made in the treatment of this case, so that the progress is still undetermined the significance of the early parental relationship as a guide to the mode of approach, has been demonstrated. From this we would not generalize that too dominant fathers should be handled with a somewhat negative, authoritative approach, but that a too dominant father's behavior should be carefully analyzed so that the causal elements, as rooted in his own parental relationships, may be utilized or "played into" by the organization concerned. If this family had come to the attention of an organization for some problem other than patient's stammering, an organization in which a psychiatrist was not available, the social worker could have utilized the same approach as described and in so doing would probably have facilitated his cooperation in whatever work was being done for the family. In this particular instance, the boy's problem, stammer-

ing, being considered by the family a medical one, made the approach by the psychiatrist essential. The actual handling of the father up to date, however, has been on a level on which a social worker could function adequately, were a so-called medical problem not involved. It may be necessary as treatment proceeds to get down to a much deeper level in the treatment of this father, in which event the psychiatrist will continue his contacts, but if this is not necessary, the social worker will gradually take him over, functioning as has been described.

Although this case as well as others cited in this paper are child guidance problems, it is believed that certain basic principles are applicable throughout the field of social case work.

When a problem is presented to a social agency by a family or one individual of a family group, it is essential that just as the social examination needs to depict not only the life experiences of each individual, but also the emotional values of these experiences for the entire group; that just as it should consider the inter-relationships and inter-dependencies of the entire group if an adequate social diagnosis is to be made, so must treatment be planned with careful consideration of the emotional interplay of all the individuals concerned, if it is to be effective.

Treatment cannot be given to any member of a family without affecting the group. In some cases the entire family must be drawn into treatment. Furthermore the approach of this or that member as well as the centering of treatment on certain individuals cannot be a random thing. In fact there must be a discriminative approach and a selective treatment emphasis in accordance with the peculiar needs of the case. Which parent shall we see first, is a vital question even at the stage of history getting, for it is frequently then that we arouse certain reaction patterns which make for a positive or negative treatment response on the basis of attention given or not given, this or that parent. It is therefore important at the time that a problem is referred that as many clues as possible be secured, such as, which parent referred the problem, the parental attitudes toward the problem and its referral, in order that at the very start the parental emotional inter-reactions may be playing into—rather than opposed.

It is generally agreed that fathers have been left too much out of the picture. This has occurred largely through the inconvenience involved in reaching them, and because of the scarcity

of their time. They are now generally interviewed at least once during the social examination and occasionally during the treatment process. The fine point of sometimes seeing the father first during the social examination and of making him the focus of treatment, if the case indicates this need, is not a very general practice due to inconvenience, in spite of a realization of his significance in the situation. It would probably be better to hold with assurance to what our interpretative techniques reveal, even though it would mean travelling slower in terms of time and fewer contacts, for it would seem that a little treatment along the line of least resistance might be more effective than intensive treatment applied as a counter attack. In this connection it might be said that we frequently depart from reality, the reality as indicated in our diagnostic evidence, out of a certain lack of courage to forebear, a fear which may be rooted in a basic lack of confidence in applying the technique in accordance with that evidence. Perhaps this lack of forebearance lies in the threat of inactivity. We, social workers, have been so infernally busy for so long a time that we probably feel positively immoral in accepting postponement. We must do something at once and as much work as possible on a case even though our efforts land us in the midst of a needless fray. In short, our personal need to be busy, to feel adequate through immediate action sometimes operates against a discriminative and effective treatment techique.

In treatment, whether or not we are doing an intensive job or a fairly superficial one, we have the basic problem of meeting in greater or lesser degree the emotional needs of the individuals concerned. Unless we do meet these needs in slight measure we are not apt to gain cooperation even on the superficial level of getting more or less extraneous things done. Unless we meet this need to quite an intensive degree we do not contribute to the emotional growth and therefore the self adjustment of the individuals with whom we are doing intensive work. Since most of our treatment with parents has been centered in mothers, we probably have more of a beginning philosophy about the handling of the mother-child relationship than of any other in the family "set-up." Therefore in the consideration of the subject of meeting emotional needs, it would be well to consid our treatment of a few of the rather typical relationships which frequently come to our attention. These mother-child relationships might be roughly classified

into two groups for the purpose of clarifying discussion: 1. The depriving mother. 2. The over-protecting mother.

These might be further subdivided in terms of the causal elements as: the depriving mother who neglects, denies or rejects her children on the basis of her own early deprivation; or who neglects, denies or rejects her children on the basis of her own early spoiling. In either case, the depriving mother is essentially an immature individual whose life experiences either because of deprivation or indulgence have interfered with her growth so that she is not sufficiently mature, to emotionally accept the responsibility of children. They are an irritant to her and so she projects her annoyance in bad handling that is essentially rejecting in nature. The protective mechanism is the primary one operating here. The children are objects of dissatisfaction.

The over-protecting mother coddles, over-protects, expresses undue concern and anxiety over her children on the basis of her own early deprivation. In this event she is completely identified with them and is probably endeavoring to re-live in them a more satisfying life than was her privilege to enjoy. This same over-protection, however, may arise out of early indulgence rather than early deprivation, in which event the mother being identified with the children is probably clinging to her own too satisfying childhood and reliving it in them. In both instances the primary mechanism operating is that of identification. The children are objects of satisfaction.

In some cases there is also over-protection on the basis of guilt over a fundamental rejection. The children were not wanted, frequently there have been attempted abortions or death wishes which have caused the guilt, so that the mother attempts to solve her conflict through over-protection. In these cases the over-protection does not seem to have so much the element of coddling as of over-anxiety and undue concern apparently as arising out of fear lest something happen to them. Therefore this over-protection frequently has a large element of deprivation. Whereas the mother who coddles on the basis of identification, is indulgent and does not want to deny her child anything, even though it is harmful. These mothers, though spasmodically indulgent, frequently deny their children privileges, etc., on an anxiety basis. The primary mechanism operating here is a compensatory one. The children are basically objects of dissatisfaction, being satis-

fying only in so far as the mother is able to solve her conflict in them.

An awareness of these emotional elements in the mother-child relationship is essential to the social worker in planning treatment for out of these variations there arise different needs calling for a selective treatment emphasis. While we are far from being ready to generalize about the handling of these various needs, our experience is beginning to suggest certain emphases, that, for example are usually ineffective in meeting the needs of the depriving mother and certain other ones that are more effective.

Take for example the X case:

Mrs. X, an over-protective mother, whose undue concern over her child apparently arose out of guilt over a basic rejection, referred her 6 years old son because of enuresis, negativism and food fads. The child was completely out of hand and responded with a consistent "no" to her nagging and continual requests. He was also markedly hyperactive.

The mother's history revealed much deprivation. She was born in Germany, the middle child in a large family who were in poor financial circumstances. The grandmother was a chronic invalid from the mother's birth, so that she had unusually heavy household duties from an early age. The desertion of the father and a few years later the death of the mother caused the breaking up of the home with placement of the children with various relatives. The mother came to America to live with relatives who did not really want her and who did not clothe her as well or give her the advantages of their own children. Being ambitious for an education she felt keenly her cousin's superiority and finally due to a feeling of being unwanted she left them to make her own way. There followed years of hard work during which she managed to go to night school finally achieving some success in holding a responsible position as office secretary. Due to overwork she gave up her job and was just trying to formulate some more satisfying plan of life when she met her husband, an educated and fairly successful business man, whom she immediately married. She verbalized that in marriage she had sought economic security and a home. She was attracted to her husband because of his superior educational advantages; the fact that he was an American citizen, had achieved some financial success and had a promising outlook for the future also weighed heavily. The marriage was satisfactory

as far as physiological adjustment was concerned. She was reasonably happy until the advent of the child. She did not want a baby so soon as she was still worn out from a life of hardship and wanted to live her own life before having a child. She became somewhat reconciled when the doctor told her that having a child would be good for her health. This expectation was not fulfilled, however, as during the pregnancy she was very ill, the birth was painful, leaving her with chronic ovarian difficulties which still persist. The child has seemed to come between her and husband. "He cares more for the boy and gives him more attention than he does me." "He is demonstrative with him and not with me." "He is too lenient with him," were some of her complaints. At the time of the referral she described herself as being worn out with the care of patient and as being "spiritually lonely." The father described the mother as being "inhuman and not at all like a mother" because of her lack of fondling of the patient. The father had had a somewhat deprived childhood but seemed to have compensated fairly satisfactorily in his work. He was more secure than the mother on the basis of his achievements. He was fond of patient with a responsible attitude toward both the patient and the mother, although he admitted being baffled by her many anxieties and was inclined to feel that the patient would be normal if not so over-protected and over-supervised.

The treatment proceeded somewhat as follows:

1. In response to the mother's request that patient be placed away from her—he was put into a school. In doing this we were considering the fact that he was unwanted, that he was an irritant so it was felt that this would give her a chance to have a life of her own for awhile, during which time treatment might be centered in bringing about a better marital adjustment, in order to prepare the mother for the eventual return of the child. In doing this we disregarded, however, her sense of guilt and her need to care for the child as a satisfying solution of her conflict. Her response was: to be greatly relieved for a short period. Then followed frequent visits to the school with constant nagging of the personnel to do more for patient. Although he received excellent care she insisted that he was being neglected and finally verbalized her remorse at having put him away. She suddenly removed him, taking him home with the vow that she's never "desert" him again.

2. At the time patient was placed in a school the mother was

sent to a convalescent home for a rest. This was constructive in that it recognized the mother's emotional need to be the patient but proved ineffectual because it added to her conflict.

3. There followed supervision of the mother in the home with emphasis on giving advice as what to do and what not to do in handling the patient's behavior. She was frankly irritated and threatened by this, saying "I spend my life doing for him and nothing is right." "I can't ignore him. He will starve if I don't insist that he eat." She would then launch into a recital of her own fatigue, her worries, her problems, her health, etc.

Recognizing that the organization should play into the parental needs of the individual it was obvious that this mother, on the basis of her early deprivation would need an indulgent parent person in her relationship with the organization; that if we centered treatment in the child we were only putting him in the position of competing with her in relation to the organization just as he had done in regard to her husband. Recognizing that in telling her what to do for the patient we became the demanding parent, who insisted that she do that much more for the child who was already a profound irritant, therefore we increased her irritation thus inducing a resultant increase in her need to nag and express her annoyance. With these points in mind, treatment proceeded as follows:

The mother was made the patient.

She was given frequent interviews with psychiatrist over a period of eleven months. For the first few months he was the indulgent parent to whom she unburdened the troubles of her past and present and confided her anxieties for the future. Gradually he helped her interpret her present difficulties in the light of her past experiences and finally in about the eighth month began to put upon her the responsibility of handling some of her own problems in the home, in regard to the patient, her husband and her friends. The social worker had intensive contact during this same period. She identified with the psychiatrist and played the indulgent mother rôle for a time. On consultation with the psychiatrist it was decided that the social worker should precede him in bringing her in contact with some of the realities in her situation. Therefore some advice was given in regard to the handling of patient. She was helped to certain social contacts, recrea-

tion interests, etc. She was frequently resistive and threatened by this but had the comfort of unloading her irritation on the psychiatrist. Finally in the eighth month when it was decided that sufficient libidinal satisfaction had been injected to offset her deprivation, as evidenced in certain indications of a gain in security in her responses to the efforts of the social worker, the social worker shifted her dependency considerably by putting it up to her to decide issues, to make her own recreation plans, to make up her mind whether or not she would be a thoroughly self-pitying, wretched person or whether she would take a hold and make the most of her opportunities as a wife and mother. It was pointed out that she now understood herself and that unless she could do her part, her problems would not be solved. The worker then gave her some ego satisfaction through assurance of our confidence in her. The mother responded during the next few weeks by taking a more active part in handling her problems, by utilizing more of the advice given her for handling patient's problems, by being less critical of her husband, by taking a more active interest in social life with him, and by taking more interest in her appearance. Gradually the psychiatrist shifted her in the same manner, with no need, however, to challenge her as the social worker had done. His shifting of her was on the grounds that she was now ready to get along without him. The social worker is now carrying all treatment, in the rôle of mother perhaps, but not the indulgent mother she once had to be. The mother is fast becoming less dependent. Whereas formerly her conversation would run on for the entire afternoon on the subject of her own ailments and problems, she recently, while spending the afternoon with the worker, talked of many subjects, books, art exhibits, current events, discussed the patient with some sense of humor and seemed to be getting some enjoyment out of life.

The father was made the focal point.

While the mother was made the patient, the father being the more secure and less problematic individual was considered the key person. He was kept in touch with developments throughout by psychiatrist and social worker. An effort was made to identify him with the organization through an ego appeal as to our need for his help. He has cooperated by handling the mother in ac-

cordance with suggestions made. He has been less critical, less demanding, more appreciative of any efforts on her part. He has made some effort to include her in his recreational interests and while rebuffed for a long period, he has recently been encouraged over her more responsible attitude so that they are on better terms than they have been since the patient's birth. And so the father is being prepared to handle the mother so that the organization can gradually fade out of the picture.

As for the patient there has been no direct treatment. Although under the care of a child guidance clinic he has been quite in the background. Lost in the shuffle, one would almost ask, but interestingly enough he has made the most decided improvement of any of the individuals concerned. Almost from the start with the mother draining off her irritation in unburdening to the psychiatrist and social worker, the emotional tension was relieved. As her irritation has decreased, she has had less need to reject him and has become more affectionate with him, and less nagging. She is still unduly concerned about his health, but she has released him to playmates. Now that she has developed some interests of her own he is having a chance to grow up. The mother now entrusts him to the care of a nurse which she would not consider doing a year ago.

While this case represents very intensive treatment of a type that not every organization could carry on, still the same emphasis has been applied effectively in less intensive cases. For example with other deprived mothers who reject their children, the social worker frequently finds it advantageous in discussing her problems with her, to grant that she has had enough troubles to make her nervous and upset, that her children are doubtless bothersome, but that all children are bothersome, and yet not all mothers are as worn out as she. Therefore she is the one to have some care. Attention can then be centered in the mother. Her response in doing things for the children can sometimes be gained through not emphasizing—"Do this or don't do that for Johnny. It is bad for him." Instead it is more effective to say, "you'll make it easier for yourself if you do thus and so." Actually one frequently gets the mother to do the very same things for Johnny as though we were centering the treatment in the child rather than the parent. The only difference lies in establishing a satisfying objective. In dealing with rejecting mothers the significant

point is the child is an object of dissatisfaction. Treatment therefore becomes dissatisfying if focused through him. In considering these basic causal elements in human behavior the social case worker is enabled to play into the individual's emotional need rather than against it.

If the time and space limits of this paper would permit one could cite case material, illustrating the meeting through social case work treatment of the emotional needs of the other mother-child relationships described above. Since this is not possible we offer the following tentative observations on the basis of experience in a number of cases.

The over-protective mother whose child is an object of satisfaction, who is re-living her life in her child is highly problematic. In some ways she is more difficult than the over-protective mother who operates on a basis of rejecting because she is generally getting so much satisfaction out of her destructive mothering that she has little desire to change her methods and therefore resists any shifts in her relationship with him, whereas the other mother, being basically dissatisfied, is a more seeking, needful person to whom the relationship with the worker has greater value. It is necessary to recognize that this over-protective mother is strongly identified with her child and that the worker will only threaten her if she identifies with the child without including the mother. A mistake frequently made in the past was that of recognizing that the child was too tied to mother and having the child's development at heart and feeling perhaps a bit irritated at so foolish and destructive a parent, the worker frequently launched into an intensive therapeutic program for the youngster, such as getting him into clubs, sending him to camp, seeing that he got sex instruction, etc. She therefore displeased the mother through a too sudden removal of her source of satisfaction, so that the need to clutch the child was accentuated and her need to reject the worker so profound that all hope of getting her co-operation was immediately lost. Frequently, too, the child was not ready for the sudden weaning, so that intimidated by the camp experience or other stimuli offered he returned to the mother, to cling all the more tenaciously and so the purpose of treatment was not only defeated but the dependency situation increased. Repeated failure due largely to such procedure has made these mothers loom large as overwhelming obstacles in

treatment. Progress has been made in some cases, however, by recognizing at the start the mother's emotional needs. It is very important that the worker treat the mother that she interest her in the child's need for certain changes in handling and that the first treatment steps be taken by the mother, rather than by outsiders for the patient. As the child is subjected to new growth experiences, the worker should see that the mother is kept in close touch with what is going on, that she be given approval for patient's improvement, that she be given new growth experiences akin to his, as substitute satisfaction for any release of him. For example, if possible, when he is sent to a club, some such interest should be injected into her life in order that she may get the feeling of continuing to be identified. If sex instruction is given to him by psychiatrist, it should be with her permission. The worker might parallel his experience with her by giving her books to read or by covering the same ground with her that psychiatrist covers with the child so that she may meet his questions and share the experience with him. All of this may seem to not be separating the child from the mother. It is well to remember that while this is the ultimate objective, the immediate objective is to induce some growth in both individuals within the security of their identification, in order to prepare them for the ultimate weaning. In a number of cases it has been observed that after about so much growth experience, the child himself begins to throw the mother off and when this point comes the mother is sometimes more ready to release him than previously. It is very necessary, however, that the worker be in close touch with her at this time in order to fortify her with approval, to give substitute satisfactions and to give her an appreciation of the possibilities of satisfaction in a growing child as well as in a baby. The treatment response of these mothers has seemed very slow and results at times discouraging. The time factor should be recognized at the start and every effort made to avoid short cuts which in disregarding the mother's needs, may endanger the treatment response.

As for the depriving mother who rejects her child and evidences same in neglect, denying and punishing, apparently without conflict: these cases have seemed to be relatively infrequent. The child is an object of dissatisfaction and therefore treatment for him is apt to be dissatisfying. If the worker identifies too

closely with the child versus the mother, she is apt to be rejected by the mother. Frequently, however, she can treat the child rather intensively and will not be resented so long as she relieves the mother of responsibility for him. It is when she involves the mother in responsibility for treatment that she meets with rejection. Bearing in mind that this mother is essentially immature, that she is frequently needful of attention, the worker might treat her so that if the mother becomes attached to worker, she will sometimes do things for her because of the resultant approval. This mother's emotional needs are apt to be so great that they can hardly be basically satisfied through ordinary social case work contact. The objective therefore, is to carry her along on a somewhat superficial level, in order to make the situation less destructive for the child. If there is a mature father, he can frequently be made a decided asset in treatment through getting his cooperation in handling her. The hopeful note for the treatment of the child lies in the fact that he is released and that one is free to concentrate in him apart from the mother. Unless his maternal deprivation is offset by a satisfying father, however, he is apt to be a very needful child so that intensive work with him over a long period of time until he is able to function adequately in spite of his parents, is usually indicated. In such a case it is sometimes well to have the child tied closely to the psychiatrist and to have the social worker carry the mother. The mother's need to resent the child because of competition with the worker is thereby minimized, while the child's tendency to identify the organization with a punishing, rejecting parent is also lessened.

In conclusion, the following tentative observations on treatment are reviewed:

1. Social diagnosis has attained an adequacy of technique which has not yet been realized in treatment. The technique involved in this phase of our work is perhaps being stressed at the expense of treatment. Since treatment not only starts with the first interview, but is the objective of the study, it should be a primary consideration.

2. The nature of the worker-patient relationship, in that the patient in seeking adequacy in the worker tends to recreate the parent-child relationship. The worker therefore needs to play a parent rôle, the nature of which should be determine by the ear-

ly parental relationships of the individual concerned. In these early parental relationships, therefore, lies one of our most valuable leads to treatment approach and emphasis.

3. The playing of the parent rôle, while it involves a close identification of worker with patient, demands a capacity for emotional detachment: in short the relationship of social worker and patient is essentially the same as that of psychiatrist and patient. The difference in treatment lies in a certain difference in emphasis. The psychiatrist treats on a deeper level, his major emphasis being to help the individual work out his problems within himself. The social worker supplements this beginning by helping the individual in the subsequent adjustment to his social environment. In individuals not profoundly maladjusted or partially adjusted following psychiatric treatment, the social worker sometimes carries the treatment in helping the individual work out certain problems within himself while relating him to his environment. She must therefore have not only an understanding of the mechanisms underlying human behavior but also an awareness of the basic emotional needs, not only as they are evidenced in an individual, but also in the interplay of the group.

4. It is particularly important that the social worker have a keen awareness of the basic factors involved for she is less protected in the worker-patient relationship than the psychiatrist for her rôle frequently involves active participation in the patient's social environment during emergent moments of emotional stress, thereby endangering through this need to participate in the drama of events, her capacity for emotional detachment without which she cannot keep the perspective essential in constructive work. Both psychiatrist and social worker to be effective professionally need to be catalytic agents in the chemical solution of human relations, that is they need to stimulate action or even change the solution without, however, entering into combination. They thus avoid coloring the reactions of others with their own emotional problems. In this process the social worker has a more highly concentrated solution in which to function in that she, as a rule, has many individuals reacting to the more varied stimuli, afforded in the social environment whereas the psychiatrist's treatment situation is a relatively controlled one.

5. Treatment cannot be given to any member of a family without affecting the group. Therefore the approach to this or

that member as well as the focusing of treatment should be done with discrimination. Leads to a selective emphasis lie in the diagnostic material, and should be held to with assurance. In this connection a little treatment along the lines of least resistance is frequently more effective than intensive treatment applied as a counter attack.

6. In focusing treatment, the more mature or secure parent is generally considered the key person in a treatment plan, although there might be exceptional situations when this would not apply.

7. Whether we are doing an intensive or superficial job, we need to meet in greater or lesser degree the basic emotional needs of the individuals concerned. This is done primarily through the relating of the patient and his family to the psychiatrist and social worker in terms of parental needs. The efficacy of treatment lies in the quality and handling of the emotional relationship of worker with patients, as revealed in the discussion of certain typical mother-child relationships.

8. The observations made on the handling of the mother-child relationship are presented only as suggestive leads to treatment. We need to carefully study the treatment responses in a large number of cases over a long period of time before coming to any definite conclusions. We can only formulate an assured technique, however, through utilizing our present understanding of the mechanisms of behavior as arising from basic emotional needs, in planning treatment. With sufficient confidence in our diagnostic material to warrant doing this consistently, and with detached observation of results obtained, we should in time build up a technique for treatment that will fulfill our diagnostic method through realizing in greater measure its purpose.

C. THE PSYCHOLOGIST

SIMON H. TULCHIN
Institute for Child Guidance, New York City

THE clinical psychologist owes much to the work of Binet for his testing technique. It was also Binet, however, who called attention to the need of treatment. I take it that as members of the Orthopsychiatric Association you are doubtless aware of the fact that Binet was the first one to introduce the term mental orthopedics. "Having on our hands children who did not know how to listen, to pay attention, to keep quiet, we pictured our first duty as being not to teach them the facts that we thought would be most useful, but to teach them how to learn. We have therefore devised, with the aid of M. Belot, and all our other collaborators, what we call exercises of mental orthopedics. The word is expressive and has come into favor. One can guess its meaning. In the same way that physical orthopedics straightens a crooked spine, mental orthopedics strengthens, cultivates and fortifies attention, memory, perception, judgment, and will."[1]

Nearly thirty years passed between the establishment of the first psychological laboratory and the publication of the first mental age scale of Binet. It took another ten years before the scale gained recognition and widespread use. It is fairly safe to say that practically no academic psychologist writing a text book in psychology before 1920 devoted any space to the discussion of tests, while it is equally safe to say that practically no text written in the last few years fails to devote considerable space to tests.

However, as yet, very little is said about treatment. The present may rightly be called a transition period. The clinical psychologist is just beginning to get recognition and help in his attempt to emerge from the I.Q.-indicator stage and to develop a technique in treatment of behavior and personality problems.

The child guidance movement in the evolution of its organization clearly recognizes the need for group attack on the intricate problems which it has to face. "The distinguishing characteristic of the mental hygiene clinic lies in the association together of psychiatrist, psychologist, and psychiatric social worker in the joint

[1] Quotation from Peterson: Early Conceptions and Tests of Intelligence. p. 276 f.

enterprise of studying completely the whole child and all of his environments, including home, school, neighborhood and companions. The emphasis throughout the study is on the dynamic interplay between the personality of the child and the influences with which he is surrounded and to which he must react."[2]

In further discussing the work of child guidance, Lowrey states that "The underlying philosophy may perhaps well be expressed by saying that what the clinic tries to do is to manipulate issues in the environment and so to treat difficulties in the individual that the child will have the greatest opportunities to realize his potentialities with the maximum of success, happiness and social ease, and yet a minimum of social difficulties."[3]

The clinical staff, then, as a group attempts to study, understand, and interpret and then treat those individuals who do not make a satisfactory adjustment to life whether in the home, the school or elsewhere.

Between the efforts of the several members of the group there is frequent overlapping. The well trained and experienced psychiatrist does, and should utilize the special technique of the psychologist, while the well trained and experienced clinical psychologist will supplement his testing with important observations of the patient which will greatly aid in the total study and interpretation of the problem.

Test findings or any other single findings as such have little value unless interpreted in the light of all the information at hand. It is this ability to interpret that differentiates the clinical psychologist from the mental tester. Specialization in the child guidance field cannot, and I believe, should not be carried to the same extreme as is possible in industry. In highly organized machine production a given worker may know only his particular operation and know nothing about the work of the man next to him. No such division is desirable in clinical work. The division of work and specialization is for purpose of better understanding of the problem presented by the patient. We are dealing with human beings who, arbitrarily or otherwise, cannot be divided into convenient segments. It becomes necessary then for each worker not only to know his own field, but to have intimate knowledge of the technique of his co-workers and to be in position to evaluate

[2] Lowrey, Lawson G.: Mental Hygiene and Child Study. DeLamar Lectures 1927–28.
[3] Ibid.

critically their work and use their material for the better understanding of the results of his own study.

This principle is gaining recognition and at the Institute for Child Guidance, for example, a definite program is worked out to train fellows in psychiatry in the principles of mental tests and interpretation as well as to train fellows in psychology in the principles and methods of psychiatric technique and social examination.

The psychologist is no longer satisfied with the mere giving of tests. He clearly recognizes their limitations and knows that much more material is needed in order to gain even partial insight into the many problems which any case presents.

In his discussion of the evolution of the devil, Menninger writes: ". . . . And next came the fallacy of the psychologists. When they discovered tests a few years ago which in a general way measured the amount of intelligence a person has, and began applying these tests to people far and wide, they found out that many people had fewer brains than had been supposed. Accordingly they began to suspect that a person who got into trouble did so because he hadn't enough brains to keep out of trouble. Feeble-mindedness became the explanation of all woes of mankind from bed wetting to bootlegging. The psychologists no longer cling, officially to this fallacy. They know, as does everyone else, that there is more to human mind than intelligence. Measuring intelligence is no more a measure of the individual's mental make-up than obtaining his weight would be a measure of his physical make-up."[4] No one knows better than the psychologist that the mere quantitative report of tests findings is extremely unsatisfactory and that at best the results of psychological tests are merely a part of a much wider study. The difficulty sometimes is in getting others to overcome the habit of expecting the contribution of the psychologist in terms of I.Q. alone.

In the development of tests the chief emphasis was first on procedure. With growth of understanding the emphasis shifted to the question of standards and norms. It is only during the last few years that the question of test interpretation in the light of other available data is being brought to the foreground.

The question of procedure is still of some importance. The ex-

[4] Karl A. Menninger, The Human Mind (New York and London: Knopf, 1930) p. 8.

pert clinician is in position to use his judgment on how closely the exact formula has to be followed without becoming a slave to it and allowing it to interfere with the proper understanding of the patient. This is dangerous ground. The academic psychologist who is giving a course in testing must insist on no variation from prescribed instruction. The clinical psychologist who studies the individual child must know when variation is important. It is not always a sacrilege to vary from standardized form.

This dilemma is extremely well described by Wells: "An intelligent South Sea Islander, observing a psychometric examination would be likely to regard it as a magic rite designed to propitiate friendly spirits in the patient's behalf. Should he observe a conscientious examiner in the apprentice stage, tightly clinging to forms prescribed, his idea would be confirmed, for none knows better than himself how slight a departure from the required formulæ will not only destroy their beneficence but may well deliver the hapless sufferer into the hands of malignant ghosts.

"Over against such esoteric views of psychometric methods is the customary and pragmatic one. The function of psychometrics is not the accomplishment of a ritual, but the understanding of the patient. The ceremony of mental tests is valuable so far as it serves to reach this end. When it fails or stands in the way of doing this, proper technique demands that it be modified. Ability to do this intelligently is what distinguishes the psychologist, properly so called, from the 'mental tester.' "[5] Any deviation from standard procedure, however, should be carefully noted and only resorted to when the standard procedure has been found lacking.

The test method is the distinctive method of the clinical psychologist. By its means very definite information of importance about the individual studied can be secured. This information is no longer limited to intelligence level alone. While still unsuccessful, yet definite attempts are being made to enter the emotional field. Qualitative studies are being made. Specific traits, abilities, and disabilities are studied and definite technique developed. Impairment or acceleration of mental growth is under investigation. Definite progress has been made in the field of educational diagnosis. Within certain limits educability is predictable. Need for special educational technique and groupings is being met. Se-

[5] F. L. Wells, Mental Tests in Clinical Practice (Yonkers: World Book Co., 1927) p. 27.

lection of children needing special teaching is possible. Technique is being developed for the determination of reasons for school failure.

The test is very much like the controlled laboratory experiment and one of its chief values is the possibility of comparing the performance of a given child with known standards. It is extremely important to bear in mind that in the entire field of child guidance there are few absolute standards. We must interpret our findings in relative terms. Caution in procedure is essential but caution in interpretation is even more essential.

Out of a primary interest to discover general laws of human behavior came the observation of individual differences—at first thought to be annoying in themselves—and later followed the extreme interest in the study of individual differences for their own importance. However, while the emphasis is on individual differences, the individual is likely to be overlooked in the process.

The development of test technique, the growth of the child study movement, the growth of progressive education, etc., are all an outgrowth of the need for individual treatment. However, once recognized, the danger lies in prescribing the same "individual treatment" to all children, defeating the very purpose and aim of the original program.

The emphasis, then, should be on individual study and all possible information about the child should be used in order to interpret the test findings. While the performance of the child is compared with that of the groups upon which the tests were standardized, the clinical interpretation must concern itself with the known standard of the group from which the child comes. It becomes important to know and consider the child's environmental situation, any special or unusual opportunities or deprivations, physical factors, any special experiences and resulting influence, study habits, etc.

Qualitative evaluation of test results is also essential. Here we run up against difficulties in terminology and lack of agreement as to which factors are to be considered essential. There is great need for special tests of judgment, attention, "energy" or "drive," etc. It may be necessary to accept some workable definitions of these and develop tests empirically.

Analysis of test finding promises important leads. For example,

in an unpublished study by the writer of equivalent mental ages made by children and adults certain qualitative differences stand out clearly. Thus in passing a number of tests to earn a given mental age the feeble-minded adult is likely to succeed more on the information type of tests, while in earning the same mental age the bright youngster is more likely to succeed on those tests w' ich depend less on mere information and life experience.

After obtaining test results our next step is to discover how well the individual functions within the limits of his abilities. The presence of given ability is certainly no guarantee that it is being used to full extent. The behavior of the individual during the examination furnishes unusual opportunity for a variety of personality observations under controlled conditions. Performance tests especially, but also all other tests, make possible observations of energy, general quality of responses, methods of attacking problems, learning from experience, evenness of temperament attitudes, general posture, alertness, planfulness, initiative, persistence, interest, spontaneity, cooperation, autocriticism, confidence, attention to detail, need for encouragment, exertion, comprehension, tendency to control situation, caution, reaction to success and failure, etc. Of course, extreme caution is essential in generalizing from above observations under test conditions to everyday experience and behavior. But similar caution is indicated in reasoning or generalizing from any other type of examination. However, corroboration of findings may be looked for in the social history and observation of others.

The psychologist has an especially rich field in his work with school problems. He can and does help in predicting general and even specific educability. He helps in developing school curricula and classification of pupils. He has the necessary technique to help in the problems created by special abilities and disabilities and related problems of variation in abilities. The study of methods of instruction lies within his field. The psychologist is especially aware of the need for more detailed knowledge about how children learn. The problem of how children learn is the best approach to the problem of teaching. The clinical psychologist is constantly at work developing necessary methods of study and habits of work as therapeutic measures.

Children are apt to find some subjects especially difficult. At the time it first arises the difficulty may be easily handled. By

the time the child is seen at the clinic it may be given the dignity of a special disability. Dislike or disability in any subject may be the result of a variety of reasons. The following are but a few of the possible reasons:

(1) An actual disability accounted for by some organic pathology.
(2) Physical handicap—poor vision, hearing, etc.
(3) General low mental level.
(4) Faulty teaching methods in particular subject.
(5) Emotional disturbance at the time when some new principles in the subject are being explained.
(6) Unwillingness to admit deficiency at the time it first occurs, for whatever emotional reasons, and failure to obtain special help.
(7) Dislike of teacher or by teacher.
(8) Faulty habits of work—how pupils learn may be more important than how teachers teach.
(9) Poor memory or fundamental operations not yet automatic.
(10) Frequent school changes.
(11) Language difficulty.
(12) Prolonged absence.
(13) Sibling rivalry.
(14) Classroom ridicule and subsequent emotional charge.
(15) Unwillingness to put forth effort.
(16) Emotional factors of various kinds.

The experienced psychologist is able to analyze the difficult and discover the underlying reasons. The causes for the difficulty determine to a great extent the remedial methods which may be applied. In many cases in which school difficulties are present the psychologist works with the child. Experience has shown that the patient is more apt to accept tutoring in a specific subject, for example, than therapy on an emotional level. The child knows that he is having difficulty and in many cases he is anxious for help. Tutoring is something concrete and something he can understand and accept. Rapport is easily established. The well trained clinical psychologist while ostensibly tutoring will take advantage of every opportunity to get at the emotional factors.

In general, the individual's behavior cannot always be so controlled that he reacts on one level in the test room and saves all his emotional problems for the next room. When emotional reactions toward his problems are spontaneously brought up the psychologist should be in position to get what he can and share his information with his co-workers. An important phase in treatment is the attempt to change the patient's attitudes toward his experiences aside from manipulation of the environment. Treatment involves continuous and active contact with the patient. In cases in which school maladjustment constitutes the chief problem it may be desirable to have the psychologist carry most of the treatment.

Another field in which experience has shown the psychologist to be more readily accepted is in the school set-up. The teacher is more familiar with tests than with any other phase of mental hygiene work. She probably gave some tests herself and has some notion of their value in school classification. She is likely to be less defensive with the psychologist and less suspicious of his technique than any other technique which might involve her on an emotional level. Later the psychologist is in position to handle the emotional problems in the situation.

Constantly growing demands are made on the psychologist to furnish vocational advice. The appeal is generally directed toward vocational tests. The sooner we recognize the fact that there are few vocational tests of real worth the better. Certain industrial concerns have developed a fairly satisfactory technique for selection of employees. However, the problem of selecting employees for a definite job is quite different from the problem of vocational advice and guidance. Vocational tests are limited and their validity often questionable. There is no one to one relationship between a given test and a given occupation. An individual with a given aptitude may be successful in a number of occupations. Other factors become important. The psychologist can help in discovering the individual's special abilities and aims and interests. The individual may have never seriously considered the choice of an occupation. An objective discussion with someone who has superior knowledge regarding possibilities, requirements, resources, etc., may bring about a clearer notion and plan. The psychologist may help the individual to evaluate his weak points as well as his strong points. The psychologist may discuss oppor-

tunities, give information, aid in planning, and in general, consider any angle which might be overlooked by the individual. He is also in position to evaluate the personality of the individual in relation to possible success.

In the child guidance clinic all members of the staff who have studied a case meet in conference to interpret their findings and evolve a treatment plan. This phase of the work is extremely important. Constant re-evaluation of treatment is essential. The psychologist takes part in these deliberations and helps to work out the treatment steps. It is at such conferences that decision is made as to the particular contribution which the various workers may make.

Then, there is the vast field of research possibilities. Many are the problems which need careful investigation and the clinical psychologist clearly has definite responsibility for contribution.

Insofar as I know the clinical group is only too glad to get help from whatever source and as the several workers develop their technique for the treatment of behavior and personality problems, there will be no lack of opportunity to demonstrate and use it.

DISCUSSION

DR. LOWREY (Chairman): First, let me express my personal appreciation to the three speakers of the afternoon. You are probably not aware of the fact that no one of them had more than two and a half week's notice that they were to take part in the Symposium. The material which they have presented, which seems to me so excellent, has been produced under considerable pressure.

The discussion will be opened by Mr. Porter Lee, Director of the New York School of Social Work.

MR. PORTER LEE: I was asked by Dr. Lowrey to come and listen to the three papers, which possibly I might get in advance, and then discuss their contents. I give you my word, if a door were over here I should be finding a way of escape at this moment. What to say about these three papers, each of which seems to me an excellent document, full of meat, and giving me a harder job of concentration than I have had in any hour and three-quarters in some time!

I should like especially, however, and briefly, to comment on the fact that it seemed to be possible to discuss the correlation of these three phases of child guidance without any controversy. I don't know why, unless the members of this Association are a hand picked crowd, because usually when I have participated in or listened to any such discussion, there has been a good deal of controversy.

It was quite a discovery to me, in terms of the possibility of eliminating controversy, when it dawned upon me that there were distinctions between professional precedence, as between different groups, and administrative precedence, as might be made necessary among various professional groups in some particular administrative set-up.

In a medical institution, you might presumably have the medical profession in charge and members of other professions in administrative functions, in subordinate capacity. Or you might find in an industrial establishment, for instance, medical men, legal men, and members of other professions occupying subordinate capacities administratively, but with no question of professional precedence involved.

This question of professional precedence, finding a place in the sun, is particularly difficult for some of us. I understand it is none too easy for the young psychiatrist when he is up against the veterans in general medical practice.

That is one thing, however, in which we have, I think, found a solution, because a child guidance clinic, making use of these three varieties of service, is in an administrative situation.

I think also there are logical reasons for the administrative precedence of the medical professions. As I see the history, the tradition, and the substance of these three professional groups at the present time, I should like to consider that background briefly under three headings. I recognize with several of the speakers that treatment begins with your first contact. Nevertheless, I am going to distinguish between a study, an examination, an inquiry, an investigation, what ever you want to call it, and another chronologically undefined place when you seem to arrive at an understanding of the problem you are dealing with, and after that a long pull in treatment when you are of course acquiring new information and making new interpretations of that information and the total situation.

Historically it seems to me that the psychologist has been equipped to make a diagnostic inquiry. The clinical psychologist increasingly, and probably psychologists in other fields, have been equipped to add to the study or investigation, the establishment of data, but traditionally psychology has not had a long history in treatment, that is to say, in administering a progressive effort to deal with a constantly changing situation, beginning at one point and trying to bring it out at some other point: with a constant modification of purpose and perception of objective, the whole process indicating an effort to influence the situation. That is what I mean by treatment. It may be wrong technically, but you take that just as my conception.

The social worker has had historically a long experience in treatment. He has learned something also about gathering information. He doesn't know much about diagnosis. He has had very little diagnostic experience, it seems to me, and very little training in the diagnostic processes in his field.

The physician, on the other hand, has been working all the time with scientific material. He has had therefore that kind of habituation which means that he begins with an undefined situation, finds out about it, analyzes it, interprets it, and tries to treat it. But when you put the three of them together and invite them to cooperate, you do tend to find overlapping. That overlapping at the present time is settled more or less in terms of administrative decision. It is not wholly what, according to the exact definition of psychiatry and exact definition of psychology, the exact definition of social work, shall each of these three do in the child guidance clinic. It is rather, given a total purpose for a child guidance clinic, a field of action defined, we, on the whole, get better results

when we assign this responsibility to the psychiatrist, that to the psychologist, that to the social worker. It has changed and is changing constantly in our experience. What the future will be I don't think any of us can tell, except that few of us that have had any contact with child guidance or mental hygiene would conceive of a future in which the leadership of the whole thing was not in thoroughly scientific hands.

Whether this whole field of behavior problems needs as much medicine, as much psychology, or as much sociology as it has had, or as those representatives of these branches have brought to it, I don't think you can tell at the moment.

I should like to make another kind of contribution, if you can call what I have said so far a contribution. I said I had noticed the absence of controversy. But I think there is a place left for controversy.

I suggest that you, as mental hygienists, having to defend yourselves against the philistines of one kind or another—the philistines to you may be social workers, psychologists, hide-bound old-fashioned medical practitioners, general public, only the emotionally involved of the world, or integrated personalities loose in the world—whoever they are, you may find yourself at some time or other in controversy with them.

I have made one of the great discoveries of my life, which has had to be lived in the atmosphere of controversy more or less, when two days ago I made the acquaintance of Mr. Schopenhauer's "Art of Controversy." If you haven't read that, you want to get hold of it.

I have not been analyzed, I may say parenthetically, but I have engaged in controversy. Well, now, an analysis takes longer than it will take you to read Schopenhauer's "Art of Controversy," but the chastening effect upon one who has engaged in controversy of seeing himself described by Mr. Schopenhauer must be somewhat analogous to the chastening effect of being analyzed.

Mr. Schopenhauer says that Mr. Aristotle before him had talked learnedly about logic, which is the art of reasoning one's way through established data to the truth. Logic is the rule by which we arrive at truth.

Dialectics is another good Greek word. I don't know just what it means, but Mr. Schopenhauer says he wants it to mean something different from what the Greeks meant. He wants it to mean the art of controversy, the art of disputation, and specifically, dialectic is for Mr. Schopenhauer the art of making what you want somebody to believe seem like truth. That is his whole purpose, and he says that he has carefully studied the literature and he cannot find that anybody has properly and scientifically examined that art and he proposes to do so. He has discovered that it can be defined and the essence of it can be established in what really are, says he, a number of tricks, the tricks by which you put it over on your adversary in the argument.

He thinks the "tricks" terminology, is a little low, so having discovered something like 42 of these tricks, he proposes to call them strategy. Therefore he gives you the 42 strategems of controversy.

Read them, and if you don't find yourself as you have defended your faith in that picture somewhere, then I am greatly mistaken.

The first strategem is, take your adversary's statement and exaggerate it a little or a great deal, so that it seems to apply to more than he meant it to. Then follow with illustrations. That is a fair example.

I advise you to get hold of that. It isn't very long, as I say, and it will be very helpful as well as being chastening, I think.

The last thing I wanted to say was this that it seems to me that everything that has been said this afternoon points to me to this focus—we do know an increasing amount apparently about personality and its difficulties and its manifestations of all kinds. We know a great deal about the canons, so to speak, of good personal relationship, the canons of rapport. We know the things we would like not to happen as physicians, social workers and psychologists deal with individuals, and we can paint in broad pictures the approaches to make, but when we come down to the real essentials of treatment, we know almost nothing.

Dr. Hartwell said that after all it comes down to this essential but indescribable thing, the art, I suppose, of handling yourself with reference to another personality, and you can't implant that. You have it or you don't, but you have got to have it if you are going to do this job.

I maintain that that art can be studied just as much as personality can be studied. There is no use in dismissing it that way and saying that we can't say anything about it. That is what they said about personality once. That is what they said about sex for centuries. That is what some people are still saying about pretty nearly everything that we have discovered to be fundamental. I want to know not only what to avoid and what general effects to produce, but how to handle myself in those continuous situations, when I am dealing either with client or patient or my own child, for that matter.

In the last analysis, treatment must register in the area within which people live, within which they are having experience, and it isn't enough for me to know, as a parent, from anybody in child guidance that I need to free my child, that I need to provide him with a different kind of experience. I have got to know specifically what kind.

How much help can we give a parent of that sort? Not much. You look up the statistics published by the divorce courts, the statistics on family desertion, anything that has to do with the breaking up of families, the data assembled from our own child guidance clinic—what breaks up families? What produces pathological behavior in children? You are not satisfied to see that stated merely in terms of attitude, but you always translate those attitudes into the conduct.

A court, before it will take any action to break up a family, will make you be precise. You can't get a divorce because your husband is cruel. You have got to say that "on the 28th of January he hit me with a shovel." Cruelty is a category defined by the law. It is an attitude which we all recognize. But the thing that breaks up a family in the last analysis is not cruelty. That is only an intellectual concept for the fact of being hit with the shovel. It is the fact of being hit with the shovel that makes that wife dissatisfied with her husband, not a label that anybody puts on it.

My point is that you always can get pathological behavior in those terms of experience.

What makes a pathological situation? Now, what makes a constructive situation? Is it a non-pathological one? Look at a non-pathological one, a situation

in which the wife does not nag, the husband no longer hits his wife with a shovel, the cooking is fair, the children have an allowance, and so forth. Describe everything you can to show that the symptoms have disappeared, and you have got a clean, decent, perfectly uninspired picture, not necessarily the kind of life that any human being would get any satisfaction out of at all.

What are the things that get into the life that mean satisfaction? They are different for you than for me. But we just dismiss it that way—we say, that all depends on the individual, that is part of the art of living.

I tell you, until we can come down in this field of mental hygiene to an analysis of the things that are, in terms of experience, constructive behavior, and satisfying incidents of life, we have done no more than begin with this job. To me, mental hygiene is nothing in the world but a means to an end. It ought to put a personality in a position, after all, to use his capacities to the fullest extent, to attain his own reasonable objectives.

What do we know in mental hygiene about objectives in life? Dr. Menninger, in that stunning book, in his last chapter, if you take him literally, does not want any objectives. I agree with the whole thing, but I have known people who spend so much time fighting drags that finally when they got rid of the drag they did not know what they were fighting for. They were left with a fighting machine on their hands and nothing else.

It is said that an integrated personality is the best way to meet the stresses and strains of life. I want to quit this mundane sphere if the only reason for getting integrated is that I will find it easier to meet discomfort and misery. I want to get integrated because it will mean greater constructive possibilities. Granted that that still must be a highly individual affair, that it is aesthetics for one, religion for another, fellowship for another, and service for someone else, nevertheless, when you come to this problem of treatment, assuming the responsibility for leading them out of the wilderness, we can't avoid, it seems to me, being aware of where they are going to find themselves.

I don't think treatment begins to arrive in this process on a scientific basis, comparing the scientific implications with diagnosis and study until we have gotten into those two areas, the one the dynamics of this rapidly changing face-to-face type of situation, and the other the whole field of values in life and the kind of constructive, satisfying incidents that make life worth living for human beings. (Applause.)

Dr. Lowrey (Chairman): I don't quite know why Mr. Lee thought his last statement was going to be so controversial. I think most of us would agree that whereas there are many people in this country who can write a most satisfying and elevating textbook on the causes of behavior disorders, there isn't any person, so far as I know, who is really qualified to write a textbook on treatment.

The second discussion leader of this afternoon is Professor Harvey Zorbaugh, of the Department of Sociology of New York University.

Dr. Harvey Zorbaugh: I think Dr. Lowrey rather exaggerated the brashness of sociologists when he said that they were thinking that psychiatrists were a little crazier than they thought themselves. Having had no professional experience with psychotic personalities, the sociologist could hardly hazard a

guess as to whether or not psychiatrists might be crazy. The only quarrel the sociologist has with the psychiatrist is as to who should have the credit for abolishing sin.

As long as my experience and training has been in research rather than in practice, and as Porter Lee has talked so admirably to the point of the previous papers, I want to say a few words about cooperative research in treatment. I am going to begin by employing the first stratagem of Mr. Schopenhauer. If my memory serves me correctly, yesterday afternoon the statement was made in one of the papers that the success of treatment establishes the validity of the hypothesis from which that treatment proceeded.

I think this is a thoroughly unsound idea, and because of the personal charm of the man who made the statement I am obliged to regard him as a menace. A look at Christian Science will, I think, illustrate what I mean. I have an acquaintance in Chicago who is a celebrated Christian Science practitioner. In past years the Mayo Clinic has sent a considerable number of neurotic people to him. They have sent these people to him because Christian Science works with neurotics. But I don't think many of us would admit that because Christian Science works with neurotics, we are obliged to say that the hypotheses from which Christian Science proceeds are thereby validated or established. I believe that the morass of conflicting generalizations about behavior with which we are faced today is largely due to the general acceptance of this criterion —to the assumption that successfull treatment thereby validates the hypothesis on which you work.

Anyone who has worked in a laboratory, either chemical or physiological, knows that it is one thing to get results, another thing to know how you get them, and still a third thing to be able to tell why you got them. The laboratory gets around this difficulty by the establishing of what is called control, and it seems to me that there is a great need for the establishment of control in the treatment of behavior disorders. I think that it is fair to characterize treatment in most behavior clinics today as "mass" treatment. A child is referred to a clinic as a behavior problem. It is discovered that he had diseased tonsils, and the tonsils are removed. It is found perhaps that he has an impacted tooth, and the impacted tooth is extracted. It is found that he has certain mental conflicts, and treatment interviews are used to resolve these conflicts. It is found that there are a score of difficulties in his family relationships and community contacts, and an attempt is made to readjust the social situation. If the outcome of the treatment is successful one can only hazard a very shrewd guess as to what actually achieved that result.

The work of Kopeloff and Kirby in testing the causative relationship of focal infections to insanity is a good illustration of what I mean by controlled experiment in treatment. Kopeloff and Kirby took two groups of psychotics selected alternately from hospital admissions. For one group they prescribed nothing but the routine treatment of the psychopathic hospital. The other group however, they assiduously studied for foci of infection which they surgically removed, thereby gaining some idea of what the surgical removal of foci of infection actually accomplishes by way of therapy. The techniques of several clinics and hospitals in working with enuresis illustrate the same thing, taking for example two comparable groups of children, using mass suggestion with one

group, and mass suggestion plus atropin or pituitary with the second group, thereby evaluating the actual therapeutic effect of the drug. Many more such controlled experiments are necessary, if we are not to come to something like an impasse in the treatment of behavior problems. Such controlled experiments will increasingly demand the honest cooperation of experts in many related fields.

As soon as one says controlled treatment, and explains what such treatment involves, someone always protests, "Why he is going to experiment with these children!" Then the objector begins to talk about the clinician's responsibility to the patient, and the problem of ethics is raised. I admit fully the responsibility of the clinician to the patient. But it seems to me that—perhaps not so much in psychiatry as in social work—we are leaning over backward in trying to measure up to our definition of what responsibility to the patient involves. I believe that too literal a definition of responsibility to the patient often handicaps rather than helps us in our treatment of the patient. The path of medicine—from the first medicine men among primitive peoples to the physician of today—is pretty largely paved with the results of controlled experiments in treatment. I see no reason why controlled experiment in treatment should not be considered as indispensable to psychiatry in its attempt to build up a body of valid scientific generalizations concerning disorders of behavior.

Dr. Lowrey (Chairman): We have had two very satisfactory and eminently wise discussions to open the series, and the entire subject is before you for what I hope will be a free and detailed debate.

Dr. William Healy: Before you get into the welter of controversy, I should like to speak about this meeting from the standpoint of impressions gained on the background of the growth of this organization. In the first place, I want to congratulate you upon the development of this plan of having a meeting for members only and having highly specialized papers, because I think we are all extremely enthusiastic about this afternoon. I hope that your successors will keep up your plan.

In the second place, I want to speak about one very general matter that intrigues me in the discussion of the afternoon, and that is the increasing amount of common sense that is being thrown into our discussions.

The papers were technical enough certainly, but they all embodied a spirit of common sense, if you look at it that way.

There was Dr. Hartwell, for example, speaking about the relationships of the psychiatrist to his patient in a way that one didn't find a few years ago emanating at all from a psychiatrist. In the ordinary hospitals for mental diseases, the psychiatrist formerly sat himself down on one side of a table with his pencil in hand and proceeded to interrogate his patients, and when he came to a child guidance clinic, he frequently carried out the same methods without attempting to develop at all the common sense attitudes that Dr. Hartwell explained to us as being absolutely necessary for getting into touch with his young people.

There is a good deal more that could be added to Dr. Hartwell's ideas, and I have no doubt that in his coming publication he will bring those out. For instance, when are you going to break up this sort of thing and so on? The same way in regard to the clinical psychologists—only a few years ago we were

all of us under the spell of this rite or ritual of giving mental tests without much evidence of its relationship to the problems of the individual. We seemed to think when we had given a number to an individual, set out a number beside his name, we had accomplished something.

Perhaps you will remember that very entertaining page on American psychometry in Siegfried's "America Comes of Age." If you have not read it you had better do so. It is a very delicious exposition of our methods.

It is impossible for us to understand the human individual without understanding his relationships to his immediate environments; and how can those relationships be understood without understanding the individuals that make up the environment?

All of this strikes me as being a growth of the aggregate of common sense which was very far apart from our earlier communications when we, each of us, took up one little element in our technique and expounded it as if it was something very much worth while and something that was somehow in itself going to answer a great many of the problems of human beings.

I submit, Mr. President, that you have three papers that are very much worthy of appearing in your forthcoming JOURNAL. (Applause.)

DR. LOWREY (Chairman): Dr. Healy has emphasized a thing which I have heard brought out before. It is one of the characteristics of Mr. Porter Lee that from time to time he makes very brilliant summarizing remarks in which he will summarize a whole field in a sentence. He once said, as I recall it, in a moment of inspiration, that child guidance work was after all "inspired common sense," which I thought was a very apt way of putting it.

DR. L. A. SCHWARTZ: If I may be permitted, I should like to add a few observations in relation to Miss Towle's paper. I was the psychiatrist who worked with those two family situations. Miss Towle made a very interesting analogy regarding the catalytic agent. I should like to carry that analogy into the fields of chemistry a little further and point out that perhaps these experiences of individuals are very similar to a solution of magnesium sulphate, the magnesium perhaps representing phylogeny and the ontogeny of the individual, the sulphate ion representing the experiences in these environments, yet both are a part of the atom at any time.

By changing the specific gravity of the solution or by introducing a foreign object perhaps at the point of saturation, you can crystallize dissolved substances. For the human, crystallization represents an experience, perhaps neurosis or conflict or even nagging, and to bring the precipitate back into solution, you must shift the solution itself. This can be done in several ways. It can be done by substitution, that is, adding more solution. Therefore, in treatment you can't use a destructive method, that is, take away anything from the individual; instead you must give him something in its place. It might be the worker or the psychiatrist representing a satisfying mother or father person. I think these two cases illustrate very clearly a happy relationship between the worker and the psychiatrist handling a case.

Since these records represent more or less a longitudinal study of experiences, we must take cross sections at times or take soundings. In this way, we can see the individual at the moment, and by careful analysis of the factors, the

motivating forces, and so on, we can arrive at a satisfactory conclusion regarding therapy, usually a substitution phenomenon for his experiences in a more socially acceptable manner.

Dr. M. B. Root: Dr. Hartwell's paper is, I think, one of the best papers I have ever heard on what, if I may be so bold, is one line of attack as to what we are doing in our interviews with delinquent children. I think particularly of boys. It is a line of analytical attack that is tending to clear up what pathology there may be, to do away with inhibitions and conflicts, and so on.

It seems to me very important to mention on the same day that this paper is read that there are other things that we must do which, of course, other people realize. Particularly in a correctional institution (in which I am) and, of course, in the home, the training of children in helpful habits is very important.

There are such homely things as training in cleanliness and teaching the children to have the proper respect for authority.

You may say that the loss of respect for authority is due to faulty training. All right, but just the same the child must acquire a decent respect for authority—which we all have; a respect for the law which in general our children don't have. In many instances they have not acquired it because it has been represented to them as a bogey man. We must train them to think of the law as something which keeps us all together, a feeling which I don't believe very many of them have.

Another important thing I believe is to give them a certain amount of ethical reasons for what we say they must do. I am very much impressed in my work with the boys, most of which is concerned with stealing, that while they know that we think it is wrong to steal they have not any sensible or decent ideas as to why it is wrong.

I am accustomed to talk over with many of them their problems of the ethics of stealing, and so many of them seem to have not the slightest idea of why it is wrong to steal. "It is wrong to steal because you get caught," they say, "because you get arrested," "because it is a sin." One boy said, "It is wrong to sin because it is like spitting in God's face."

Well, it is. But, as far as their telling me that it is wrong because it isn't decent, because it isn't fair to anyone else, because it is doing things which, if we let go on, would make society back into a chaos, they haven't any conception of that.

While of course many of my boys are too immature to have any real conceptions of it, to give them that attitude of the reasons for rules and laws I think is a very important thing.

One other thing which Mr. Lee brought out very well is that we must do also some very positive things, we must help the child to learn how to live to be more happy, teach him and get him interested in various sorts of recreations and games, which of course is done, but which I think is worth stressing. Teaching him about reading and about the arts when he gets old enough, and so on.

Mr. S. J. Beck: Mr. Tulchin mentioned some points that I think are well worth discussing. One especially, is the question of an interest in psychology only in relation to doing one job and no more. I have wondered many times whether that attitude is not a function of what you might call two variables, one the unintelligent attitude of the physician himself, and, on the other hand,

the lack of training on the part of many psychologists who have had no more than academic training in mental testing, with some courses in statistics, but have not had at least one year of experience in a community clinic. I have wondered whether it would not be possible to try to get some method—really I suppose the psychologist should be more interested in this than the medical people themselves—of seeing to it that when a clinical psychologist really attempts to be one, that he ought to have in addition to his academic training, about one year of actual training in a community clinic.

DR. LOWREY (Chairman): That is one of the things that it seems to me was exemplified in all three papers, the fact that these groups as well as many others have finally discovered the human being as the total personality involved in the series of more or less total situations. That is a striking point that hasn't always been to the fore in the training of any professional group.

DR. ELIZABETH SEEBERG: No matter how well trained the psychologist may be in giving tests and interpreting them, there is a limitation in the material itself. A psychologist can go just so far in adding to the understanding of that person's mental mechanism. On that account, I believe it is essential, if psychologists are going to continue as real clinical psychologists, that they should have the opportunity to study the motivational mechanisms. Psychology should have to take a place in the treatment plan, to deal with the individual as a whole rather than with the particular things that can be gotten out of a series of tests.

DR. LOWREY (Chairman): Professor Zorbaugh made a point or two concerning which I should like to add a little personal testimony.

It is certainly proper to question the validity of the conclusion that the hypothesis is accurate because treatment results are obtained.

In attempting to analyze some of our work one great difficulty I find is to ascertain the real reasons why a given case improved. What happens when a case comes to you and you see the patient, we will say once? The father and mother are seen once in the study and they suddenly report that the problems are all cleared up. Why? What happens?

The second thing is that there is a tendency in psychiatry and in the mental hygiene field to make a single observation the basis for very broad, sweeping generalization. It so happens that several times this past year that tendency on the part of psychiatrists has been gently but firmly drawn to my attention. It is a fact that we are frequently scientifically inadequate in our approach to and study of the problem we are dealing with, in the sense that having found some type of causal relationship, or at least one we believe to be the causual relationship in a given case, we proceed to draw entirely too broad and too sweeping generalization from that single observation or from a few observations.

There is no question in my mind that we need a much greater critical spirit, and, if you like, a much more statistical approach, if we are to determine the validity of some of the concepts with which we work.

DR. T. R. ROBIE: Suppose, as happens to some of us, we have to interview from two to four and sometimes six or eight cases in a day's time and we don't have a chance between cases to run to a dictaphone and have our interview put down in writing at the time. After a long day's arduous labor, we come home

and try to think up what the first patient said and what the third patient said. Sometimes it is rather difficult. I for one wonder whether it is possible for everyone to carry out so much work without taking some notes as they go along.

Dr. E. S. Abbott: May I as a psychiatrist say that I have always been in the habit of taking notes in the presence of the patient? It depends on how you do it. Usually I say to the patient, "My memory is not very good and you won't mind my taking notes. I find that if I don't I do not remember enough and when I want to review the data I have collected, if I don't take notes I haven't enough."

My memory is not of the type that will retain so many data and so I have to take notes. I have not found anybody thus far, in quite a long practice, who seemed to object to it or in whom it aroused any particular complex or anything of that kind.

We used in my earlier days to have that same attitude, that you must not take notes in the presence of a patient. In fact in my earlier days we did not even talk to the patients about their psychoses.

Dr. T. R. Robie: There is one more point I wanted to add along that line, and that is the question of which is the greater of two evils, losing some very valuable analytical material or having the ill effect on the patient of writing in his presence.

Dr. S. W. Hartwell: Certainly I think since the rapport to be established is the chief therapeutic weapon, getting the details into the written record is of secondary importance to establishing that rapport.

With adult patients I have never had any objections from the patients in taking notes as I frequently have done. I find that all children are conscious of it. Nearly all children let you know in some way or other that they do not like to have what they say written down. That is my experience.

Dr. Elizabeth Seeberg: May I make this comment? It seems to me that the essential point is not just remembering particular details in the interview but the essential elements in the interview, the emotional expressions and the essential factors found. Making notes during the interview does not allow for that sort of survey of the whole situation, and I find it very useful to make an outline right after the interview in which the important points, as far as we can judge, are jotted down and later dictated. In that way the skeleton of the interview remains and the details come later in association when you dictate the interview. I have found that very useful.

Dr. Daniel Griffin: Possibly there may be still another angle to the question of taking notes. I recently had an Italian woman come to me who had been to two other physicians for treatment during the past year. She came back for a third visit, which was rather unusual, because she had not made even a second visit to either of the others. I knew both men and they had told me their experience with her, so I was curious to ask her why she had returned to me. She was profoundly psychoneurotic. She said, "The reason I came to you was you wrote down everything and I knew you must be intensely interested."

Miss Eleanor Johnson: I don't know that this is entirely *apropos*, but in

giving the Binet test, it is very helpful in going over the results of course to have the actual words or the reply as far as possible. With a good many people it is not possible to remember. Sometimes it is very desirable to have the very interesting phrases of the children. There is a question of taking notes in the presence of the child. I have been asked by children, "Why are you writing something? What are you writing?" It is often possible to say, "Well, I am glad you said that, and I want to remember it," or, "I like what you said, and I want to remember it." This seems to meet the child's needs so far as I can judge.

DR. LOWREY (Chairman): It sounds to me, from the direction this discussion is taking, as though a most useful symposium next year would be on the art of interviewing and recording the results of your interview. I will pass that suggestion on to the incoming president whose job it is to worry about next year's program.

DR. M. B. ROOT: On this matter of not taking notes, I have done as Dr. Abbott suggested, I have usually told boys that my memory was not very good, which is unfortunately true, and that I wanted to remember what they were saying.

Dr. Hartwell says that boys have seemed to take offense at it. I have been on the alert for it, I am sure, and it does not seem to me that except with one or two boys they have ever minded it a bit.

One other point, patients, as well as ourselves, have poor memories, and I have found it often very good, on interviewing boys later, to read over to them or tell them what they said. Boys whose attitudes have changed, who see things in a different light, often can hardly believe that they said certain things. It is not wise to tell a boy things when you are not sure of them. It has helped me a great deal to be able to show them what they said and often congratulate them on the improvement in their attitudes.

DR. H. C. SCHUMACHER: I have had occasion to see some patients after they had been seen by other members of my staff or the psychiatrists of the staff, both because I was interested in checking up on younger men and in cases after the former psychiatrist had left. On quite a few occasions I have had it come back from the youngsters that they felt much freer to talk because I was not taking notes. They felt that the other fellow was putting everything down. I think, as has been brought out by Dr. Hartwell, that it very frequently interferes with the production of good rapport to take notes in their presence.

On the other hand, if a child says something in the way of a word or phrase that bears on his condition, one can take that down, because one can show the child that that is something that is new and interesting, something that has not come in his experience before. The youngster then believes that he is contributing something to the psychiatrist. You can jot that down, and frequently it refreshes your memory when you need it.

On the other hand, I think it is quite essential that the men train themselves in being sufficiently interested, if I may put it that way, in their patient, that the salient facts about that patient will be borne in mine. Under such conditions, I don't believe it is very difficult to remember what eight or ten children have said to the extent of four or five pages per child.

MR. HURD: This morning in discussion the question was raised as to what technique was best used with children in getting a good rapport, and I think someone raised the question, how are you going to make a child feel that nothing he says will be used against him. If you take notes, it seems to me that is quite a point in making him feel that some day this may be brought up to face him. I have found in working with Dr. Hartwell's boys that he doesn't take notes on, that he has had very good success with them.

DR. LOWREY (Chairman): If I may add a bit of personal testimony, I have worked both ways. I have had situations where I made notes and situations where I did not. It does seem to me that there is a good deal of variations in the response of individuals. I have certain individuals with whom the taking of notes promptly produces a considerable amount of suspicion as to what it is all about, what I am going to do with this material. In certain other cases, I find the situation such that they very definitely wonder why I don't take notes, why what they have to say is not important enough for me to make notes.

But in general it has been better, taking it by and large, not to take notes during the interview. If you have to do it, it seems to me that you must explain in some way that will allay any suspicion the child may develop of why you have to do it.

DR. BRADFORD J. MURPHEY: We have had some experience about taking notes and finally have abandoned it altogether and found that we could solve the problem by so arranging our work that we dictated on that particular case immediately after finishing the interview and not prolonging the interview to any great length. We do this for two reasons. One is because the child becomes quite tired and bored sometimes, and another reason is because our memory has limits.

DR. LOWREY (Chairman): Now I am going to ask the three main speakers of the afternoon to close the discussion, each from his own point of view, starting with Dr. Hartwell.

DR. HARTWELL (Closing Discussion): The two men who asked me questions have gone. One man implied something that I did not like. He seemed to think that I did not want to understand what happens. Well, that is what I am going to use the rest of my life doing, trying to understand what does happen when these children seem to take me into their dynamic environment and I seem in some way to be able to help them. I don't much suppose I am going to succeed, but goodness knows I should like to know about it if I could.

On the other point of the record, putting these things confidentially told into the record, I have a rather definite rule about that. If the things told me by the child would cause any trouble, either legal or family trouble, were it to become known, it does not go into the record. If a child tells me that he has seen his mother having sex relations with the chauffeur, I don't put that into the record. I don't see any reason why I should put it into the record.

On the other hand, if he tells me that he is having mental conflict or believes that his father hates him, I put that in the record. I don't expect his father ever to see it. It would do no harm if he did. But my rule is rather closely defined in that respect. We are careful of our records in the clinic. Nothing goes in that would ever cause any serious trouble. I can just as well put in, "This boy has had some unfortunate observation of sex," or I can put it in rather vague terms

that would mean nothing to some prying individual that happens to see it. It goes in the record as far as the record is valuable psychiatrically, but my record would not be very valuable to a lawyer who was seeking material for a divorce.

MR. TULCHIN (Closing Discussion): I think I should like to say that the important keynote sounded by Mr. Lee, Professor Zorbaugh and some of the others points to the great need for careful research and investigation of our methods in dealing with the entire situation.

There is need for a special committee that would go into the entire question of professional education and training. I think it might be worth finding out no matter what the particular contribution of the psychiatrist or psychologist or social worker may be, when they are working by themselves, than when they are working together their contributions presents an entirely different *gestalt*.

MISS TOWLE (Closing Discussion): I think there were no particular points raised for discussion from the social service angle. Since the discussion has centered so largely on the matter of recording, it might be interesting to say that from the standpoint of the social worker, we advocate a very discriminative technique in the matter of recording. Some types of material, such as the physical development of the child and anything that involves dates and addresses, the parents are generally better content to have recorded. On the really confidential material, that would not adapt itself very well to a pencil anyway. It is of the nature that most people remember, and there is no need to use a pencil at such times.

DR. LOWREY (Chairman): May I say in closing this session, that I have appreciated very deeply the honor the Association has paid me during these two years of my presidency. I have also appreciated the support that the organization as a whole has given.

I am happy to report that there are approximately fifty new members who were voted in today, and the chances for a large and successful meeting next year look better than they ever have before.

The seventh annual meeting is hereby adjourned.

DIFFERENCES IN PERSONALITIES IN THE SURVIVING PAIR OF IDENTICAL TRIPLETS*

H. W. NEWELL, M.D.

Virginia State Mental Hygiene Clinic, Richmond, Virginia
Formerly Fellow-in-Psychiatry, Institute for Child Guidance, New York City

I. Introduction

THE purpose of this paper is to study the effect of environment and disease upon personality. The material used is that of the surviving pair of a set of identical triplets. Since biologically the process of identical triplet formation is so similar to that of identical twin production the pair will be spoken of hereafter as twins. The selection of this pair is for the purpose of reducing the effect of heredity to a minimum.

II. Review of Literature

A great deal has been written about the process of twinning and triplet formation. Newman (1) gives an excellent description of this process in animals and in man, inquiring especially into its causal factors. It is not the purpose of this paper to discuss this phase of the subject but a very brief review may help to serve as a background for the central theme of personality differences in twins and triplets.

Newman considers that, from the standpoint of the biologist, the terms twins and triplets should only be applied to those of monozygotic origin, since fraternal and unlike sex twins or triplets have no more similarity than brothers or sisters. He also states that identical triplets are one hundredth as frequent as identical twins.

The evidence for the monozygotic origin of identical twins, triplets and quadruplets is both direct and indirect. Newman (2) studying specific polyembryony in the nine-banded armadillo found that altho quadruplets are the rule in this animal only one corpus luteum is found at a time. Arey (3) describes a human twin embryo 12.3 mm. long with the two yolk stalks coming from

* Read at the seventh annual meeting of the American Orthopsychiatric Association, February 21, 1930. New York City. Based on a study made at the Institute for Child Guidance.

a common yolk sac. The fact that human twins have a single chorion is no proof of their monozygotic origin. Arey (4) finds that in tubal twin pregnancies there is probably a fusion of the chorions since monochorial twins are fifteen times as frequent as in uterine twin pregnancies. Lauterbach (5) gives evidence of the existence of two kinds of twins. If all twinning were dizygotic one would expect the ratio of the Male-Male, Male-Female, Female-Female combinations to be 1:2:1. However, the United States census on 20,021 pairs of twins shows 6,639 Male-Male; 6,898 Male-Female, and 6,484 Female-Female combinations or a ratio approximating 1:1:1. He concludes from this that the addition of the monozygotic type of twinning increases the proportion of like-sex twins. Other indirect evidence of monozygotic origin is the close morphological duplicity of identical twins and triplets.

The most important causal factor of the twinning process, according to Newman (1) is a period of developmental slowing during or just before the period of gastrulation resulting in the formation of two axes. In most animals this period of quiescence is usually associated with abnormal metabolic conditions. Patterson (6) found that in armadillos it was due to delayed placentation. Whether this is true in humans or not is still a question.

The close physical resemblance of identical twins is a matter of common observation. Lauterbach (5) studied 200 pairs of twins and found the coefficients of correlation based on physical measurements of the like-sex twins (which included some fraternal twins) to range from .70 to .93 while those of the unlike sex twins (which included no identical twins) ranged from .50 to .59. Newman and Patterson (7) found that the coefficient of correlation of the physical measurements of nine-banded armadillos was .90.

The criteria of identity in twins is not definitely established. Siemens (8) and Lauterbach (5) agree on the following criteria:

1. They must be of the same sex.
2. Close similarity of:
   (a) Features.
   (b) Physical measurements.
   (c) Body build.
   (d) Hair color, texture and distribution.
   (e) Iris color and minute markings.

To this list Siemens adds:

3. Close similarity of:
   (a) Skin color, texture and pigmentation.
   (b) Shape and size of ears.
   (c) Shape and irregularities of teeth.

Komai, (9) Lauterbach (5) and Newman (1) agree that either close resemblance or reversal of symmetry of finger-print patterns is of extreme importance.

Similarities have been found with psychological tests as well as with physical measurements. Thorndike (10) in his study of the intellectual resemblance of twins neither selected identical twins, nor did he distinguish like-sex from unlike-sex twins. Merriman (11), using three standard tests for intelligence, found coefficients of correlation in like-sex twins ranging from .86 to .92, while in unlike-sex twins they ranged from .50 to .86. Lauterbach (5), using the Standford Binet Test with 210 pairs of twins, found a coefficient of correlation in like-sex twins of .77 and in unlike-sex twins of .56. Wingfield (12), using less standard tests, studied 102 pairs of twins and found a coefficient of correlation of .82 in like-sex twins and .59 in unlike-sex twins. From the like-sex group he separated 45 pairs of identical twins and found a coefficient of correlation of .90. It is interesting to compare these figures with those of Pearson (13) who found brothers and sisters to have correlations ranging from .52 to .61.

There are many references in the literature of similar disease processes occurring in identical twins. Wilson and Wolfsohn (14) give an excellent review of the literature concerning mental disease in identical twins. Murray (15) describes twins whose education and careers are remarkably alike. Gesell (16, 17, 18) describes several pairs of twins whose physical and psychological measurements are strikingly alike. Richmond (19) describes a pair of identical twins who developed psychotic histories of striking similarity, altho they lived apart much of the time. Altho these studies describe the personalities quite well they have little to say concerning environmental or causal factors. The earliest attempt in this direction was made by Francis Galton in 1883 (20). He studied 35 pairs of twins and concluded that none of the environmental conditions studied, except disease, exerted a pronounced effect upon their psychic traits.

The most interesting recent development in this field has been the tendency to study identical twins reared apart. The assumption on which these studies are based is that, if we are dealing with approximately identical hereditary factors, then surely in a study of twins reared apart we can study the effect of environment on physical and mental traits free from the necessity of constantly paying tribute to heredity. This assumption is probably so true that the most valuable contributions of the future to the age-long controversy as to the relative value of heredity and environment will lie in such studies very intensively carried out.

The first of these studies was published by Popenoe (21) in 1922. From this study, which was rather superficial, the author concludes "that the psychical make-up of the individual is very largely settled by the time he is born." Three years after this paper by Popenoe, Müller (22) presented a study of twins reared apart. In this study the twins were found to have very close intellectual abilities, in the Army Alpha and Otis Advance Tests, and marked personality differences as tested by the Pressey X-O and the Downey Will-Temperament Tests. The next year Barbara Burks (23) criticised Müller's study on the grounds that the tests for temperament used were not sufficiently well standardized to draw valid conclusions. She also criticised formula he evolved for proving identity. We feel that an equal important criticism is that in Müller's study the social history is so meager. If the main value of such a study lies in determining the effect of environment on personality why describe the environment so sketchily?

In 1929 H. H. Newman published three cases of twins reared apart. His data were so conflicting that he wisely avoided drawing conclusions. In his first case (24) the tests showed a marked difference in mental abilities but quite a similarity in tests of emotional reactions. This is in marked contrast to Müller's findings. In Newman's second case (25) he found practically the same thing as in his first. However, in his third case (26) his results more nearly agreed with those of Müller. These results lead one to wonder which are more strongly inherited, intellectual abilities or emotional traits. The variability of the tests for emotional traits makes their use of questionable value. The same criticism applies to Newman's cases

as was mentioned for Müller's, namely, that the social history is inadequate to explain any differences that may be discovered in the personalities of the twins studied.

III. Presentation of Data

As mentioned before, the material used in this study is that of the surviving pair of a set of identical triplets studied at the Institute for Child Guidance in 1929. They were fourteen years old at the time of study. For convenience we shall call them Esther and Naomi, altho these names are fictitious. A few other changes have also been made in non-essential data in order to further disguise the case. This has been done since so much of the material is confidential.

1. *Referred Problems.* Esther was referred by the visiting teacher because her teacher thought she was mentally defective, being one year behind her twin sister in school and being especially poor in reading. It was also mentioned that she had been nervous since her infantile paralysis when she was two years old and that she lacked self-confidence and had queer ideas, feeling that people were against her. Naomi was studied merely because she was Esther's twin.

2. *Social History.* For the sake of brevity, only the facts that are significant as we see them, will be mentioned. The father, a Russian Jew, was brought to this country, when he was three years old by his widowed mother, to whom he was very devoted. He married at twenty-four and now at forty-two is quite successful, running a grocery store. He has many social contacts and claims to be happily married. He was especially devoted to his only son, the second child, and was very much upset when he died, at the age of three, of what the doctors called pneumonia. Since his son's illness came when Esther was ill with what was called infantile paralysis he came to believe that his son caught his illness from Esther. In telling the social worker of this incident he first said that his son died of infantile paralysis, changing it to pneumonia. The children's nurse said she had always heard that the boy died of infantile paralysis. Esther told the psychiatrist that her brother caught his fatal illness from her. After his son's death the father was depressed for several months. Since then he has shown an unusual sympathy for men who were depressed. He is disappointed in not having another son but favors his youngest daughter, Mary, saying that, "She is just like the boy who died." He is rather indifferent to the other children who ask favors of him only when he is in a good mood. He admits often pretending to be sick to get a rest.

The mother, a Roumanian Jewess, came to this country when she was three years old. Altho never in love with her husband she seems happy with him and is proud of his success. She is fond of social life and likes to help her husband manage the store, hiring a maid to look after her children. She has always been very dependent on her mother for advice in household matters and relied a great deal on her in bringing up her first child. She refused to pamper her children and wants to harden them to make them independent. She, too, was upset

at the death of her son. She, more than the father, has favored Naomi and has neglected Esther.

The sister, Florence, eighteen years old, is in college and plans to study law. In high school she had good marks, debated well, was socially prominent and played the piano well. The brother, Louis, was born in 1913 and died in 1916 of what the doctor called pneumonia. He was very bright and was idolized by his father. The sister, Mary, eleven years old, does good work in school and plays the violin well. She is obviously her father's favorite for the reaons mentioned above.

The twins, Esther and Naomi, the second and third in a family of four living children, were born December 20, 1914 as triplets, the third child, a girl, being born dead and clinging to Esther. Esther at birth weighed two to three pounds and was wrinkled and old looking. Naomi who was born a half an hour later weighed three and one-half pounds and seemed fatter, having a smoother skin. As the mother was quite ill after this birth neither child was breast fed. Esther was on a bottle for 2 and one-half years and was weaned quite easily while Naomi was weaned with difficulty after being on the bottle for three years. Esther toddled at two years of age before she was paralyzed, and Naomi walked at two to two and one-half years of age. When Esther was two years old she became ill with what was called infantile paralysis. She was in the hospital two months and was not visited once by her mother who later told the social worker, "I almost forgot I had a child there." Esther returned with a paralysis of her right arm and

TABLE I
SCHOOL RECORDS

ESTHER					NAOMI			
Deficiency	Work	Conduct	Grade	Date	Grade	Conduct	Work	Deficiency
	C	A	1A	2/ 1/21	1A	A	B+	
	B	A	1A	6/30/21	1B	A	A	
	B	A	1B	2/ 1/22	2A	B+	B+	
Reading	B	B+	2A	6/30/22	2B	A	B+	
All Subjects	C	B+	2B	2/ 8/23	3A	B+	B	
Reading	B	B+	2B	6/29/23	3B	A	B+	
	C	A	3A	2/ 8/24	4A	B+	B	
Reading and Spelling	B	A	3A	6/30/24	4B	B+	B	
Reading	B+	A	3B	1/30/25	5A	B+	B	Low in Reading
Spelling	B	A	4A	6/30/25	5B2	A	B	
Slow	B	A	4B	1/30/26	6A2	B+	B	
Phys. Slow	B	A	5B2	6/30/26	6B2	A	B	
Spelling	B	A	6A	1/30/27	7A2	A	B+	
Spelling, Grammar, History	C	A	6B2	6/30/27	7B2	B	B+	
	C	A	7A3	1/31/28	8A4	B	B	
Failing	C	C	7B2	6/29/28	8B3	B	B+	
Reading, Grammar, and Spelling	..	..	8A	1/31/29	H.S.	...	...	

leg. She had to relearn to walk at three years. Her speech was retarded so that she did not say words until three years and sentences at six years. Naomi was saying words at two years and sentences at two and one-half years. Toilet habits were established in Naomi at three years but were delayed until six years in Esther partly because she could not unbutton her clothes. Both parents and teachers say that Esther is not as bright as Naomi. They have always looked so much alike it has been difficult to tell them apart except by their behavior.

The School Record (Table I) shows that of sixteen terms recorded Naomi received better marks than Esther in eleven. Naomi's progress was regular whereas Esther repeated grades 1–A 2–B and 3–A and skipped 5–A. Therefore, Naomi was one-half grade ahead of Esther from 1–B to 3–B, one grade ahead from 3–B to 4–B, one and one-half grades ahead from 4–B to 6–B and since then has been one grade ahead. It should also be noticed how often deficiencies in reading and spelling are recorded for Esther. It was stated by Esther's teachers that they frequently promoted her when she did not deserve it merely because they felt so sorry for her.

Since babyhood Naomi has been favored by her parents. She has been allowed to work in the store and important errands have been entrusted to her while Esther has had none of these advantages. Esther, on the other hand, has been constantly, compared unfavorably with her twin both by her parents and her sisters.

The social history gave the following picture of Esther's personality: She is described as a girl who has retained many of her childish ways, who seems to crave affection and who shows a drive to gain attention, this last being especially noticeable in school. She is a poor worker in the store and feels inferior to her twin physically, intellectually and socially. She is nervous, high-strung, unpopular and shows almost no ability to make friends. She is suspicious of people, thinking that they are talking about her, and altogether she seems to be a very unhappy girl.

In contrast to this Naomi is described as being more mature and showing less drive for attention and affection. She is a capable worker and feels superior to her sister in every sphere. She is more stable and is popular, being able to make friends easily. She is trustful and cheerful and seems on the whole to be a rather happy girl.

3. *Physical Examination.* The physical measurements (Table II) show many of them to be strikingly similar although some of them have been affected by Esther's paralysis. Both girls look very much alike. They show a marked similarity of skin color and texture, both having freckles over the forehead, cheeks and chin. They both have dark-brown, straight, medium soft hair. The hair distribution all over the body was very similar. The hair whorl was clock-wise in both girls. The iris in both was greenish brown. Their iris patterns were strikingly similar, both having brown radiating striations and two fine concentric rings near the outer border of the iris. Their ears were similar in size and shape. Both had similar indentations and a prominence of the upper fold of the right ear. Their teeth showed a similar overbite. Both had large central incisors and their lower central incisors were crowded. The upper right lateral premolars in both were internally displaced. Table III shows rather striking similarities in the processes of decay.

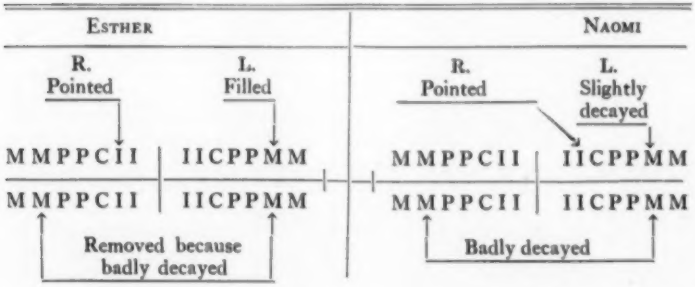
TABLE II

MEASUREMENTS

ESTHER		NAOMI
56 in.	Height	58.8 in. (3 mos. later)
−9.6	Per cent	−5.9
71 lbs.	Weight	79 lbs.
−14.4	Per cent	−19.3
76.	Pulse	70.
94/58	Blood Pressure	106/64
29.75 cm.	Height—Floor to Pubic Crest	31.25 cm.
20.2 cm.	Horizontal Nipple Line to Umbillicus	20.2 cm.
15.2 cm.	Chest—Ant.—Post.	16.5 cm.
20.6 cm.	Chest Lateral	20.6 cm.
68.5 cm.	Chest Circum.	71.0 cm.
17.0 cm.	Head—Ant.—Post.	17.0 cm.
14.0 cm.	Head Lateral	14.0 cm.
49.5 cm.	Head Circum.	50.3 cm.
50.7 cm.	Hair Line to Chin	50.7 cm.
5.5 cm.	Between Pupils	5.5 cm.
3.5 cm.	Mouth Diameter	3.5 cm.
5.5 cm.	Ear Length	5.5 cm.
33.5 cm.	Biacromial	34.5 cm.
23.2 cm.	Biiliac	23.2 cm.
17.3 cm.	Between Nipples	17.6 cm.

TABLE III

TEETH


ESTHER
NAOMI
R.
Pointed
L.
Filled
R.
Pointed
L.
Slightly
decayed
M M P P C I I | I I C P P M M
M M P P C I I | I I C P P M M
M M P P C I I | I I C P P M M
M M P P C I I | I I C P P M M
Removed because
badly decayed
Badly decayed

A study of the finger prints (Table IV) shows a close reversal of symmetry. The formulae used were those described by Wilder and Wentworth (27). Esther's right and Naomi's left hand have the same patterns. Although the other hands differ with two fingers, still radial (R) and ulnar (U) loops are so similar to each

TABLE IV

FINGER PRINTS

	ESTHER					NAOMI				
	Thumb	Fore	Mid	Ring	Little	Thumb	Fore	Mid	Ring	Little
Right	U	U	U	W	U	C	U	U	W	U
Ridge Counts	17	16	12	?	6	10	16	7	?	7
Left	C	R	U	C	U	U	U	U	W	U
Ridge Counts	11	18	15	17	9	18	3	16	11	7

TABLE V

FINGER PRINTS

ESTHER		NOAMI
	Primary Classification	Hands Reversed
L/L	1st Pair	W/L L/L
L/W	2nd Pair	L/W L/W
L/W	3rd Pair	L/L L/W
L/L	4th Pair	L/L L/L
W/L	5th Pair	W/L W/L
	Classification Number	
13/2		9/18 13/2

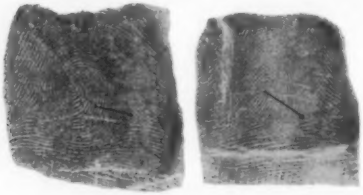
other in form, and composites (C) and whorls (W) are so similar that with the primary classification system used in most police courts both girls would have the same classification number if their hands were reversed (Table V). Even the ridge counts show a certain similarity. Figure 1 shows a comparison of two fingers of reversed hands. The thumbs are composites (C) and the middle fingers are ulnar (U) loops. The loops seem to point in opposite directions but they each point toward the ulnar bone. Analysis of the palm prints offer no clue as to similarity. This fact corroborates the findings of Lauterbach (5) who states that palm print formulae show no more resemblance in like sex than in unlike sex twins.

The neurological examination in the case of Esther can be summarized as follows: the right arm and leg show atrophy, weakness and moderate rigidity. The deep reflexes on the right are more active than on the left. The Babinski is positive on the right and negative on the left. There is slight weakness of the left facial muscles. These findings certainly point to upper motor neurone involvement and possibly also to lower. The significance of these findings will be taken up under "Discussion."

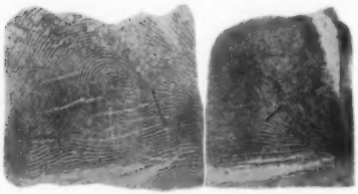
4. *Psychological Examination.* The psychological examinations show a consistent difference between the performances of the two girls. Allowing for the fact that the tests were made six months apart, we find on the Stanford-Binet Test (Table VI) a difference in mental age of fifty-one months and an I.Q. of twenty-nine points. On the Performance Tests (Table VII) we find an average

difference in mental age of forty-seven months. On the Stanford-Achievement Test (Table VIII) we find a difference in educational age of forty-four months. In all of these tests Naomi tested consistently higher than Esther. These differ-

FIGURE 1



Esther, Left
Thumb Middle



Naomi, Right
Thumb Middle

FINGER PRINTS

TABLE VI
STANFORD—BINET TEST

ESTHER		NAOMI
3/2/29	Date	9/4/29
14 yrs. 2 mo.	C.A.	14 yrs. 8 mo.
10 yrs. 0 mo.	M.A.	14 yrs. 9 mo.
71	I.Q.	100
8 yrs.	B.A.	10 yrs.
4 yrs	Range	8 yrs.

Both Passed

IX. 1, 2, 3, 4, 5 X. 1, 2, 3, 4, 5 XII. 7

Both Failed

XII. 4, 5 XIV. 1 XVI. 1, 2, 3, 4 XVIII. 1, 3, 4, 5,

Esther Passed (Naomi Failed)

XII. 6.

Naomi Passed (Esther Failed)

IX. 6 X 6 XII. 1, 2, 3, 8 XIV 2, 3, 4, 5, 6 XVI. 5, 6 XVIII. 2, 6.

TABLE VII

PERFORMANCE TESTS

ESTHER				NAOMI
2/16/29		Date		9/4/29
14 yrs. 2 mo.		C. A.		14 yrs. 8mo.
M.A.	Score	Test	Score	M.A.
13 yrs. 6 mo.	....	.....Porteus Maze.....	....	15 yrs. 0 mo.
9 yrs. 9 mo.	24	...Kohs Block Design...	85	14 yrs. 8 mo.
9 yrs. 0 mo.	37	.....Healy P.C. II.....	59	13 yrs. 0 mo.
10 yrs. 0 mo.	10	..Ferguson Form Boards..	17	17 yrs. 0 mo.
	42.3	.....Total Scores.....	59.8	
10 yrs. 6 mo.	....	.....Average M.A.....	....	14 yrs. 11 mo.

TABLE VIII

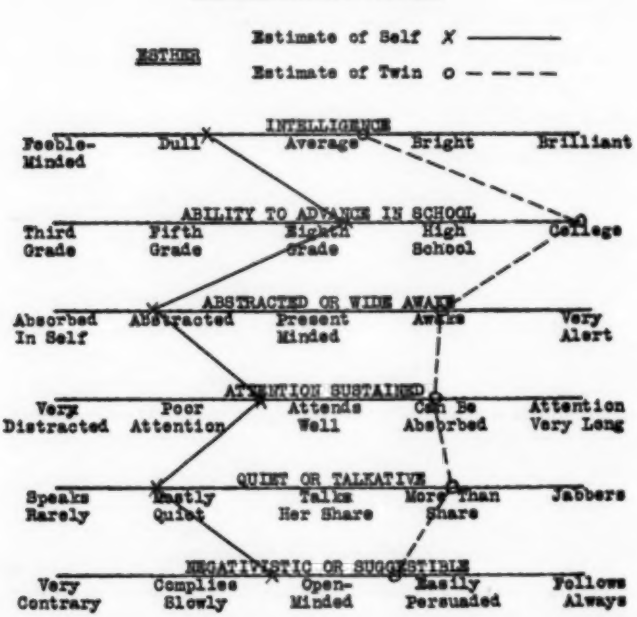
STANFORD ACHIEVEMENT TEST

ESTHER					NAOMI	
2/14/29			Date		9/4/29	
14 yrs. 2 mo.			C.A.		14 yrs. 8 mo.	
8A			Grade			9B
Grade	E.A.	Score	Tests	Score	E.A	Grade
			Reading:			
4.0	9 yrs. 10 mo.	21	1. Word Meaning.....	63	15 yrs. 4 mo.	9.3
3.0	8 yrs. 5 mo.	11	2. Sentence "	43	12 yrs. 4 mo.	6.5
2.0	6 yrs. 11 mo.	4	3. Paragraph "	68	12 yrs. 7 mo.	6.8
2.9	8 yrs. 4 mo.	36	4. Total.....	174	13 yrs. 3 mo.	7.5
			Arithmetic:			
5.7	11 yrs. 6 mo.	96	1. Computation.....	144	16 yrs. 2 mo.	+10.0
3.5	9 yrs. 4 mo.	28	2. Reasoning.....	88	13 yrs. 11 mo.	8.1
4.9	10 yrs. 9 mo.	124	3. Total.....	232	14 yrs. 11 mo.	8.9
3.4	9 yrs. 2 mo.	4	Nature Study and Science.	54	13 yrs. 0 mo.	7.3
3.5	9 yrs. 4 mo.	3	History and Literature...	51	14 yrs. 2 mo.	8.2
4.4	10 yrs. 4 mo.	11	Language Usage.....	34	14 yrs. 5 mo.	8.5
5.4	11 yrs. 3 mo.	92	Dictation.....	150	14 yrs. 2 mo.	8.2
4.0	9 yrs. 11 mo.	27	Total Averages.....	69.5	14 yrs. 1 mo.	8.2

ences are much more more marked than those found by Merriman (11), Lauterbach (5) and Wingfield (12). They are twice as great as those found in Newman's first two cases (24)(25) of twins reared apart and from five and one-half to seven times as great as average differences he found in a study of fifty pairs of identical twins reared together (25). The significance of this will be taken up under "Discussion."

Since Esther gives a history of consistently doing poor work in spelling and reading, and since she is now left-handed (forced by her paralysis) whereas her twin is right-handed, she was given tests for reading disability as described by Marion Monroe (28) and Orton (29)(30). This examination showed poor work on all types of reading tests. She showed many errors in vowels (substitution and omissions) and confusion of consonants. She always confused "m" and "n." There was only one error with reversible letters. She did very good mirror writing with her left-hand. Mirror reading was slower and contained more errors

FIGURE 2

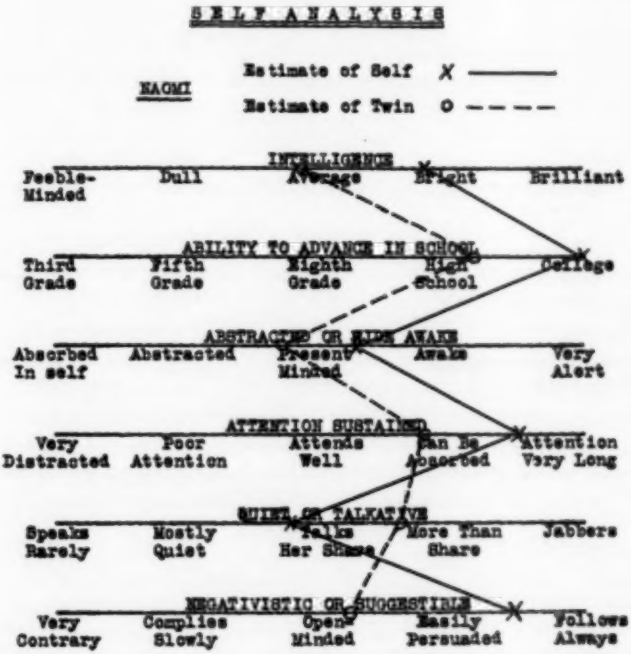


than reading without the mirror. She stated that she used to teach children to write mirror fashion. Picture naming was correctly done. In the test for orientation of drawings she reversed one drawing 90 degrees and another 180 degrees. She used her left-hand primarily but used her right-hand to assist in the form boards. In writing she used her left hand and placed her paper upside down. Although these findings are not typical of an extreme case of reading disability, they seem to indicate that she may have formerly had a more marked degree of disability. If this were true it would seem probable that Esther was originally right-handed, like her twin, and was forced into left-handedness by her paralysis.

This would then reverse the usual sequence of a left-handed child being forced into right-handedness by training.

5. *Psychiatric examination.* In the psychiatric examination of Esther it is interesting to note that when the examiner first saw her in the waiting room she was writing on a piece of paper. It was later learned that she was figuring out when Naomi first passed her in school. At first Esther was tense, shy, and seemed afraid. She sat on the edge of her chair, holding her right (paralyzed)

FIGURE 3



arm behind her. Later when she was more at her ease she placed her right hand in her lap and massaged it with her left hand. She showed that she felt definitely inferior to her twin and said that she could not think of any way in which she excelled Naomi. This is also rather strongly brought out in a Self-Analysis Chart devised by E. K. Wickman, part of which is shown in Figure 2. She is evidently very jealous of Naomi and her first wish was to surpass her in school. Her earliest memory was when she was re-learning to walk after her paralysis and how anxious she was to catch up with her twin who walked well then. Her second wish was to have lots of friends, adding that she has only two friends she

can trust. Even her best friend goes back on her at times. She has a hard time making friends, saying, "I'm too crabby. I get mad too easily."

The psychiatric examination of Naomi showed her to be more cheerful and self-confident. She seemed much happier and more aggressive than Esther. She feels superior to her twin and describes her interest in elocution in contrast to Esther's shyness. Her feeling of superiority is shown in her Self-Analysis Chart (Figure 3). She describes herself as being more sociable than Esther and she has a desire to emulate her sister Florence who is bright and popular.

IV. Discussion

It is rather obvious that this case would have more scientific value if the factors involved were less complicated. Thus studies on identical twins are needed in which emotional factors alone (such as parental attitudes and feelings of difference) are responsible for personality differences. In this case the complicating factors in themselves are interesting and offer grounds for speculation.

The first complicating factor is their triplet birth. The existence of identical triplets has been definitely shown by such workers as Randall (31), Suzor (32) and Williams (33). If this case were one of identical triplets, then the two surviving girls could be considered as identical twins as far as the similarity of their inherited traits was concerned. The proof of this would then depend on whether the criteria of identity have been adequately met. (This will be taken up below.) On the other hand there have been some intra-uterine factors that may be of importance. Thus it was stated that Esther was born with the dead triplet clinging to her; also that Esther at birth looked less well nourished and weighed slightly less than Naomi. It seems probable therefore, that in the uterus Naomi was favored nutritionally. What effect this might have on total development, physical and mental, it would be difficult to state.

Since the value of this study depends on whether the criteria of identity are adequately met, the facts supporting the assumption of identity will be listed:

(1) Close similarity of features.
(2) Many of the body measurements are either identical or very similar. However, many have been affected by Esther's paralysis.

(3) Marked similarity of:

(a) Body build.
(b) Hair color, texture and distribution.
(c) Skin color, texture and pigmentation.
(d) Iris color and minute markings.
(e) Shape and size of ears.
(f) Shape and irregularities of teeth.

(4) Close reversal of symmetry of finger prints.

(5) They are of the same sex.

These findings satisfy the criteria set up by Siemens (8), Lauterbach (5), Komai (9) and Newman (1).

Another complicating factor is the illness Esther had when she was two years old. The exact nature of this illness is problematical. It occurred during an epidemic of infantile paralysis. The neurological findings of atrophy and weakness seem to indicate lower motor neurone involvement, while the rigidity, increased reflexes and the positive Babinski on the right indicate upper motor neurone involvement. Whether Esther had an encephalitis, a polio-encephalitis or a cerebral form of poliomyelitis it is difficult to state. Several cases have been reported in the literature of atrophy, rigidity and spasticity following epidemic encephalitis: Carr (34), Guillain and Alajouanine (35) and Weisenberg and Alpers (36). That encephalitis is not uncommon in early childhood is shown by Kenkes and Saenger (37) who analyzed seventy-two cases and found thirty-three in the first two years of life. Whatever the lesion in this case is it is probable that the left cerebral cortex has been involved the most.

It is difficult to explain the differences in the psychological findings of the two girls. It is improbable that they are due to heredity since usually there is a close similarity between the psychological tests of identical twins. (*Op. cit.* (5) (11) (12).) It is improbable that these differences are due to environment since it was found that they were much greater than those found in twins reared apart. (*Op. cit.* (22) (24) (25) (26).) The effect of training is also probably not significant since the tests for achievement showed smaller differences than those which are supposed to test "innate ability" more closely. For these reasons it seems likely that Esther's early illness has had some

effect on her mental development. The literature about the effect of encephalitis on intelligence offers very little positive help. Sherman and Beverly (38) in a review of the literature show that many of the earlier writers affirm that there is a deterioration of intelligence following encephalitis. However, in none of the articles cited were standard tests of intelligence used. The authors reported on twenty cases of children with personality changes following encephalitis and stated that repeated tests showed no deterioration. Buchanan (39) stated that in Great Britain, "It is rare that the intelligence or the mental faculties of a child—are sufficiently impaired for him to come under the Mental Deficiency Act." Simon and Miller (39) after pointing out how inattention and excitability may affect the apparent level of intelligence state that in no case studied by them "has the mental development been below the (chronological) age of the child at the time of the onset of the encephalitis." T. Clark (39) states that, "As a general rule, these cases show no appreciable diminution of intellectual faculties. Alterations of intelligence are much more frequent in younger children." Thiele (40) states that in the children he studied the essential intellectual processes are well preserved. Marshall (41) states that the general intelligence is not affected to any appreciable extent, and that it is quite exceptional for one of these children to have an I.Q. below 85. The author has not been able to find any case reported in the literature where intelligence tests had been used before and after the encephalitis. It is possible as T. Clark (39) has suggested that the effect of Esther's illness was greater than usual because she was so young at the time of her illness.

Other factors that might have affected the psychological tests are: Esther's reading disability, her feelings of inferiority and dislike for all types of tests, and her left handedness and paralysis which may have affected her performance tests.

The factors causing the marked difference in the personalities of these girls are largely environmental and disease. Although the heredity of identical twins is never identical, still it is more nearly so that any in other pair of organisms, so that for all practical purposes hereditary factors as causes of differences are reduced to a minimum. Even disease can be thought of as an environmental factor. In this case it certainly was not inherited.

The effects of Esther's disease may be stated somewhat as follows: Her development was retarded; she was handicapped physically by her paralysis; she was handicapped psychologically by her mental retardation and reading disability. When these effects were kept in constant contrast with her twin who developed more normally who showed none of these handicaps and who progressed more rapidly in school one would expect to find in Esther marked feelings of inferiority and of jealousy. This was brought out strongly in the psychiatric examination.

Of the more obviously environmental factors contributing to the difference in the personalities of these girls the following may be mentioned: Naomi has been favored by both the mother and father since babyhood. The mother forgot to visit Esther when she was ill in the hospital, while the father not only believed that his favorite son caught his fatal illness from Esther but he made Esther believe this also. Naomi was allowed to work in the store with her parents and she was entrusted with many important errands, whereas Esther was never given these responsibilities and she was constantly compared in an unfavorable light with Naomi. With an environmental background like this it is not surprising to find that Naomi is the more aggressive twin, that she is more capable, has more self-confidence, is more cheerful, is more responsive to people and makes friends more easily than Esther. In contrast to this it is not surprising to find that Esther, besides feeling inferior to and jealous of Naomi, is timid and shy, seems unhappy, is suspicious of everyone, is unpopular and has a drive for affection and security.

VI. Conclusions

The foregoing study of a pair of identical twins who showed marked differences in personality and intellectual ability would seem to justify the following conclusions:

(1) Since the criteria of identity have been adequately met the hereditary, as causative, factors are reduced to a minimum.

(2) Since the factors of heredity, environment and training have been ruled out as the main causes of the marked differences in intellectual abilities the conclusion seems justifiable that this difference was mainly caused by an early illness, in one of the twins, characterized by involvement of the left cerebral cortex. Whether this illness was encephalitis, polioencephalitis or a

cerebral form of poliomyelitis it is impossible at present to state.

(3) This illness probably forced this twin from right to left handedness and produced a reading disability of the type described by Orton and Monroe but in a reversed form.

(4) The personality picture of lack of self-confidence, seclusiveness, feelings of inferiority to and jealousy of her twin sister, and general suspiciousness as found in one of the twins is due in this case to a physical and intellectual inferiority to her twin, to having been shown less attention and favoritism by her parents, to having been constantly compared unfavorably with her twin and to her failure to compete successfully with her twin in any sphere of activity.

(5) Conversely, the personality picture of self-confidence, cheerfulness, responsiveness to people and ability to make friends easily, as found in the other twin, is due in this case to physical and intellectual superiority to her twin, to having been favored and shown more attention by her parents, to having been constantly compared favorably with her twin and to her ability to compete successfully with her twin in every sphere of activity.

BIBLIOGRAPHY

1. Newman, H. H. The physiology of twinning. Univ. Chicago Press. 1922.

2. Newman, H. H. The ovum of nine-banded armadillo. Growth of the ovocytes, maturation and fertilization. Biol. Bull. **23.** 1912.

3. Arey, L. B. Direct proof of the monozygotic origin of human identical twins. Anat. Rec. **23:** 245–253. 1922.

4. Arey, L. B. Chorionic fusion and augmented twinning in the human tube. Anat. Rec. **23:** 253–262. 1922.

5. Lauterbach, C. E. Studies in twin resemblance. Genetics **10:** 525–569. 1925.

6. Patterson, J. T. Polyembryonic development in tatusia novemcincta. J. Morphol. **24.** 1913.

7. Newman, H. H. & Patterson, J. T. The limits of hereditary control in armadillo quadruplets. A study of Blastogenic Variation. J. Morphol. **22.** 1911.

8. Siemens, H. W. Diagnosis of identity in twins. J. Hered. **18:** 201–209. 1927.

9. Komai, T. Criterion for distinguishing identical from fraternal twins. Science **65:** 280. 1927.

10. Thorndike, E. L. Measurements of twins. Arch. Phil. Psych. and Scient. Method **1:** 1–64. 1905.

11. MERRIMAN, C. The intellectual resemblance of twins. Psychol. Monog. **33**: 1–58. 1924. Psych. Rev. Co., Princeton, N.J.

12. WINGFIELD, A. H. Twins and orphans: the inheritance and intelligence. Dent. 1928.

13. PEARSON, K. On the inheritance of mental and moral characters in man and its comparison with the inheritance of physical characters. Biometrika **3**: 131–190. 1904.

14. WILSON, S. A. K. & WOLFSOHN, J. M. organic nervous disease in identical twins. Arch. Neur. & Psych. **21**: 477. 1929.

15. MURRAY, G. H. A study of twins in health and disease. Lancet. **208**. No. 5298. p. 529. 1925.

16. GESELL, A. Mental growth of the pre-School Child. Macmillan, 1925.

17. GESELL, A. Mental and physical correspondence in twins. Scient. Month. **14**: 304; 415. 1922.

18. GESELL, A. Infancy and human growth. Macmillan. 1928. Chap. 14 P. 272–298.

19. RICHMOND, W. The Psychic resemblances in identical twins. Am. J. Psychiat. **6**: 161–174. July 1926.

20. GALTON, FRANCIS. Inquiries into human faculty and its development. Macmillan Co. London 1883.

21. POPENOE, PAUL. Twins reared apart. J. Hered. **13**: 142–144. 1922.

22. MÜLLER, H. J. Mental traits and heredity. J. Hered. **16**: 433–448. 1925.

23. BURKS, BARBARA, S. Determining identity of twins. J. Hered. **17**: 193–195. 1926.

24. NEWMAN, H. H. Mental and physical traits of identical twins reared apart. (Case I) J. Hered. **20**: 49–64. 1929.

25. NEWMAN, H. H. Mental and physical traits of identical twins reared apart. (Case 2) J. Hered. **20**: 97–104. 1929.

26. NEWMAN, H. H. Mental traits of identical twins reared apart. (Case 3) J. Hered. **20**: 153–166. 1929.

27. WILDER, H. H. & WENTWORTH, B. Personal identification methods. Richard G. Badger, Gorham, Boston, 1918.

28. MONROE, M. Methods for diagnosis and treatment of cases of reading Disability. (Preface by Dr. S. Orton.) Genetic Psychol. Mon. Vol. **4** No. 4 & 5. 1928.

29. ORTON, S. T. Physiological theory of reading disability and stuttering in Children. New England J. Med. **199**: 1046–1052. 1928.

30. ORTON, S. T. Specific reading disability; strephosymbolia. J.A.M.A. **90**: 1095–1099. 1928.

31. RANDALL, L. M. Acute hydramnios and homologous triplets. Am J. Obst. & Gynec. **8**: 766–770. 1924.

32. SUZOR. Univitelline triplets (case). Bull. Soc. d'obst. et de gynéc. **15**: 609. 1926.

33. WILLIAMS, J. W. Placentation in quadruplet and triplet pregnancy. Bull. Johns Hopkins Hosp. **39**: 271–280. Nov. 1926.

34. CARR, A. D. Muscular atrophy of the spinal type in chronic encephalitis. Arch. Neurol. & Psychiat. September 1926.

35. Guillain, G. and Alajouanine, T. Combination of extrapyramidal rigidity and syndrome of amyotrophic lateral sclerosis after epidemic encephalitis. Rev. Neurol. March 1926.

36. Wiesenberg. T. H. and Alpers, B. J. Decerebrate rigidity following Encephalitis. Arch Neurol. & Psychiat. July 1927.

37. Kenkes and Saenger. Encephalitis in children. Monatschr. f. Kinderh. **32:** 334. 1926.

38. Sherman, M. and Beverly, B. I. The factor of deterioration in children showing behavior difficulties after epidemic encephalitis. Arch. Neur. & Psych. **10:** 329. 1923.

39. Buchanan, G. S., Simon, T., Miller J. C., & Clark, T. Les sequelles mentales de l'encephalite letharique. Bull. de l'Office Internat. d'hyg. pub. **19:** 764–802. 1927.

40. Thiele, R. Zur Kenntnis der psychischen Residuärzustände nach Encephalitis epidemica bei Kindern und Jugendlichen, insbesondere der weitereren Entwicklung dieser Fälle. Berlin 1926.

41. Marshall, R. M. The restless, naughty, encephalitic child. Brit. M. J. Sept. 1927.

PERSONALITY DIAGNOSIS BY MEANS OF THE RORSCHACH TEST*

SAMUEL J. BECK
Boston Psychopathic Hospital

THE Rorschach test was devised by Hermann Rorschach, a psychiatrist. The broad claims he makes for it, include: first, it is an accurate gauge of intelligence; second, it probes into the affective life of an individual, giving an index to his emotional stability or instability; thirdly, it gives some insight into the unconscious mechanisms in personality.

A test which can give so much information about a patient would seem to be a clinical instrument of the first order. Intelligence tests we have been having for many years and their numbers have been legion. But it is an old story that it is one thing to know a patient's intelligence and another to know what are the other elements in his personality; and what these other elements will permit him to do with his intellectual equipment, or as the case often is, what they will compel him to do with it. And it is nothing new that an objective instrument giving a reliable index to a patient's emotional life is still the great need of clinical psychology.

Rorschach went a bit further in his claims, namely, that his test not only gives a general insight into the emotional life, but that it makes possible the classification of individuals into specific reaction types. Differential reaction patterns, he reported, are obtained by the test for different classes of schizophrenics; for the two principal affective psychoses; for the organic mental disorders; and for epilepsy. In other words it is an instrument for exact diagnosis of mental disorder.

All this seems much to ask of one test, especially since it happens to consist of nothing more complicated than ten ink-blots. To be sure they are not a random set of blots. Rorschach selected these ten, symmetrical, variously colored, and variously configured blots, only after considerable experimentation over several years with many different designs and individuals, checking his

* Read before the seventh annual meeting of the American Orthopsychiatric Association, February 21–22, 1930, New York City.

results with case histories and material gathered in psycho-analyzing patients. The present set, and Rorschach's norms, published in 1921, were standardized on 405 persons.

I believe that the exact nature of the test, together with an idea of its technique, can be made clearer by showing you at once the lantern slides of the designs. At the same time I shall read you sample responses given by one mentally defective patient; one adult normal of superior intelligence; one psychotic; and one behavior girl.

Here is Card I.

The feeble-minded: "a rat," because these hooks reminded him of claws; and "pie." In both responses he reacted not to the entire design, but to details of it; also, he reacted to the form of the detail. But in one case it is a sharply perceived form, in the other it is vaguely perceived.

The superior normal: "might be a butterfly or a moth." This is a whole response; it is a reaction to form; and it is sharply perceived.

The psychotic: "an autumn leaf," because of the irregular edges. Also a whole response, and a poorly perceived form.

Again, "a bird, or skeleton of a bird," because the white spaces are where you can look through the skeleton. This is classified as a white space form response.

The behavior girl: "a map"; a reaction to the whole design.

Card II. The feeble-minded: "red onions"; again a detail, with both color and form dictating the answer.

The superior: "like two clowns, playing with their hands—tongues out—knees together—." A whole response once more; and this time movement is seen.

She goes on: "like a lamp in a room—and shadows are reflected." The reaction here is to the white space, and also to the differential shading of the black-white pattern.

The psychotic: "something like a dog's face here." This we classify as a rarely perceived detail.

"Like a dancer in the middle. Here is the waist-line—here the powdered hair, —and here the skirt." Again a white space detail, movement is involved, and an original.

"Makes me think of a furnace, the inside of a furnace." A pure color reaction.

The behavior girl: "a turkey." A whole response, reaction is to form and color. An original.

Card III. The feeble-minded: "two dogs, two cats, fishes, a house." Various details, all are poorly perceived forms and usually absurd originals.

The superior: "like two men bowing at each other with their hats in their hands." A movement response.

The psychotic: "two men with boxing gloves"; movement is seen.

"A cat chasing its tail." Once again, movement.

The behavior girl: "If I were to name the picture I'd name it, 'Competition,' because the two are pulling apart. But it might be 'Humanity'." Here it is movement which is seen; but notice the abstractions: "Competition," "Humanity."

Card IV: For the rest of the cards, owing to the lack of time, I shall only show the cards and omit the responses of all but the behavior girl. Here she said: "This would symbolize to me some animal, as a lion. It would be more than one. It looks like three to me. It would show some sort of love, by the way it's clashed together." Notice again the abstraction; and this time it's love which is abstracted, out of what to you and me is only an innocent ink-blot.

Card V. "This appears like a worn out butterfly." "Worn out because of these gray colors; as though the rain had washed it out." An abstraction again, but the topic is now not love; it approaches death.

Card VI. "An insect, this upper part." Quite an average response.

Card VII. "This would symbolize some butterfly. This would be a dead butterfly. This would be the fragrance of it. Or it would remind of the beauty of it; as though the beauty had died." Death and dying beauty now come to the surface.

Card VIII. "This would suggest—if it were a picture, I'd call it the 'Ladder of Life." Because the climbing reminds her of a ladder, and the globe is the globe of life. And so not only death, but also life is in the content of this girl's responses.

Card IX. "Only thing I can think of is the colors would suggest something. Green would suggest grass. The blooms—any flower. This brownish, in the fall, when everything comes down." Again an abstraction, and once again, dying nature.

Card X. "Can I say anything that comes to my mind? I think of life in general. One color would suggest happiness." Pink means happiness to her. It is her favorite color. One—gaiety. The blue. Again abstractions, and this time: gaiety, happiness, life in general.

Such are the responses, and it has been obvious, I believe, that these four individuals reacted quite differently to, saw quite different things, in the same set of ten cards.

How, now, does this test differentiate for intelligence? Suppose we compare the response pattern of our feeble-minded patient with the one at the other end of the intelligence curve, the superior normal.

The summary of responses shows that whereas the feeble-minded reacted with only one "whole" response, the superior reacted with sixteen. Of the form responses only twenty-eight per cent of those given by the feeble-minded could be classified as sharply perceived; for the superior person they formed seventy-five per cent. Fully seventy per cent of the feeble-minded responses were animals; only thirty-five per cent of the superior's were such. Of good originals the feeble-minded has nine per cent,

as compared with twenty-seven per cent for the superior; but he has forty per cent poor originals and the other has none. Only one movement response was given by the feeble-minded, the superior gave six.

Now I can not go extensively into the psychology behind these types of responses beyond mentioning briefly Rorschach's theoretical arguments that the capacity to bring details of a situation into a whole is a function of associational activity; the ability to perceive forms clearly depends not only on sharply defined memory impressions but also on the ability to chisel them out from the mass of the mind's material, when the stimulus presents itself, and to evoke those that are most adequate to the stimulus; the low percentage of animal response is an index, in this test, of the ability to depart from the obvious, since the blots are so formed as to evoke animal responses readily, and it requires a wealth of associational data together with a not too rigid mental functioning to free one's self from these obvious reactions; ability to see good originals is also a function of wealth of associations. The movement response I shall discuss fully presently but will mention here that Rorschach found them indicative of the capacity for inner creativity, to live "auf geistigem Gebiet," which is hardly a habit of the mentally defective.

If now I mention that the feeble-minded individual was a patient in the New York City Children's Hospital for the mentally deficient, with a Binet mental age of four years three months, and an intelligence quotient of 36, while the other individual holds an important professional position in the Boston Psychopathic Hospital, it seems logical that she should react with sixteen times as many whole responses; nearly three times as high an average of sharply perceived forms; only half the animal percentage; originality that points to true wealth of associations; and six times as many movement responses, those that point to the "geistigem Gebiet."

And if the Rorschach test proves itself a valid and reliable instrument, it would seem that as an intelligence gauge it has the advantages, first, that previous school experience can not influence the results; second, exactly the same test material is applicable to the entire range of intelligence; thirdly, the material is sufficiently unlike a mental test to free the subject from emotional inhibition incident to the test situation itself and so gives

the clinician a more accurate picture of the equipment available for intellectual functioning in life generally.

However, it is not in the Rorschach as an intelligence test, but in its technique for probing into the emotions that I suspect you are chiefly interested. And now to describe this technique.

You remember that I classified some of the responses as "Color" and some as "Movement." It is in the relation that Rorschach found between these responses and certain components in the personality, that he made his important contribution to the problem of personality diagnosis.

For, in the color responses Rorschach found an index to the individual's tendency to live his life exteriorly to his own self; the tendency for the emotions to bubble over. And three types of color response appear: pure color, which is the representative of the uninhibited, impulsive egocentricity; color, with form also a factor, indicating a facile excitability and irritability, at times, suggestibility, or again, a quick sensitivity; and form, with color a lesser factor, in which we see the striving of the individual, consciously directed, to restrain his egocentrivity, in accordance with the need to adapt himself to the environment.

The movement responses are a sign—and I am quoting Rorschach's words—of "the ability to create the new, the original; it is the capacity for creativity. In its highest development it is what we call artistic inspiration, religious experience. Perceptions of motion must then be a sort of instrument for gauging inner creativity, the power for introversion."

So the movement responses are an index to the tendency towards interiority of psychic life; the color responses are an index to exteriority. You will recognize here Jung's introvert and extrovert personalities. Rorschach acknowledges his debt to Jung but differs from him in some essentials.

Now movement and color and the psychic elements to which they point are not reciprocals of each other. The existence of either does not exclude the other. Either may be present alone; both may be present, in equal quantities, large or small; they may be present in unequal quantities, with either factor predominant. It is the relative proportion of the two that is of the greatest significance for diagnosis. For it is an index of an individual's tendency to balance his instinctive impulses by a certain amount of inner living; when this amount is too great we have the patient

who lives entirely in his own fantasy; on the other hand the patient may become altogether uninhibited in the outward expression of his egocentric impulses. The amount of color taken absolutely gives an index to the fluidity of the emotional life. Taken in its relation to the movement response it is a measure of the emotional life which comes to expression. This is the "Erlebnistypus" of Rorschach, a term which may best be translated as "type of affective experience."

An example will make the principle clearer and I shall illustrate by citing two kinds of Erlebnistypus, of types of affective experience, as they showed up in the test. Again I will use the normal adult as the point of reference and will compare her with the psychotic patient of the Boston Psychopathic Hospital.

The normal showed six color responses; the psychotic, ten and a half. Greater affective fluidity on the part of the patient is here indicated. Of movement responses the normal again showed six; the psychotic fifteen. Here a tremendous amount of fantasy living on the part of the patient, is pointed to. Consider now the proportion of the two factors in the two individuals. For the normal it is 6:6 or ambivalent. For the psychotic it is 15:10.5, a ratio of three to two or clear excess of fantasy living; and, according to Roschach test interpretation, clear evidence of a world going on within the patient's psychic life. In fact, this finding, considered in the light of patient's other responses, that it to say, in the light of her entire production, made possible the following conclusion (I am quoting now from my report on this test): "The response pattern as a whole is consistent rather generally with Rorschach's findings for a disordered schizophrenic reaction type. More specifically it indicates what Rorschach calls the productive paranoid." And now to quote from the psychiatrist's findings: "A diagnosis of true paranoia is made. Were the affect shallow or the personality deteriorated we would throw this patient into the schizophrenic group."

Let me now interpret more fully the record of one patient, our behavior girl. She had been referred to the psychiatric clinic of the Jewish Board of Guardians, of New York City. Her intelligence was indicated as high average or better. And in fact according to her Army Alpha score she was at the seventy-first percentile of the general population in intelligence.

Now as for the Erlebnistypus, or affective experience: four pure

color, one color form, two form color, for a total valuation of eight color responses. Of movement responses, only two. Here is clear excess of color responses, leading us to expect unstable affectivity, striving for the impulses to express themselves. We recall now that the content of her responses were abstractions dealing with fragrance of dead butterflies, dying autumn, love clashed together, happiness, the ladder of life. We suspect defeated desires. From the presence of the color element we have confirmation of the presence in her of such desires. Confirmation of the fact of conflict is also found in certain elements of the response pattern, discussion of which would be technical and would take me much beyond my time limit. Now, with affective strainings present but thwarted and with conflict indicated, we might feel less uneasy in this case if the movement responses appeared in greater quantity. For it would indicate that patient was obtaining some satisfaction in fantasy livings, had some escape into the inner self. But movement is low, and the content manifests considerable preoccupation with dead. We wonder about suicidal tendencies.

And what are the facts? The case history shows an only girl, of sixteen, with a brother now twelve, and to whom she is greatly attached. Until recently they have slept together. Evidences of incest wishes are present. The girl is not physically attractive. When the social worker suggested a physician, in order that certain obvious physical disorders might be investigated, the answer was, "No. I am afraid of the verdict."

In closing I want to summarize briefly some results I have obtained with sixty-nine feeble-minded children at Randall's Island. This was my first study with the Rorschach test.* I undertook it when I was the Institute for Child Guidance in New York City, as a fellow in psychology and I carried it on with the help of Dr. D. M. Levy, chief of staff of the Institute, to whom I am indebted for my first acquaintance with the test. The results show low incidence of "whole" responses, with a regular rise of "whole" responses for rise in mental age. A similar rise was found in per cent of sharply perceived forms. Animal percentage was high and showed some very interesting variations apparently due to affective inhibition in patients. Original response was high. In one, relatively unimportant respect, Rorschach was not substantiated: this was his Do, or oligophrenic response. He was fully substan-

* Reported in full in the American Journal of Psychiatry, 10, 19–52. July, 1930.

tiated in his claims for Erlebnistypus: the average movement response was 0.75 as against an average of 3.70 for color; with a D/SD difference of 6.15, or clear statistical indication of a reliable difference in favor of dominance of what Rorschach calls the extratensive tendencies. And those of you have had experience with the feeble-minded know that it is their exterior living which is dominant, and that they do little living "auf geistigem Gebiet."

A COMPARATIVE STUDY OF THE KOHS BLOCK DESIGN TEST*

IRA S. WILE, M.D. *and* ROSE DAVIS
New York City

THE two-hundred and fifty children who provided the data used in this study were referred within the past year to the Children's Health Class, Mt. Sinai Hospital. Chronologically they range from five to sixteen years inclusive, and represent the various public school sections of the city. They present problems of maladjustment, ranging from simple school or home difficulties easily remedied, to those demanding mental and emotional re-education and social readjustment. When roughly classified according to the original complaint as stated by the referring agency they fall into the following groupings: physical disabilities; school failures; home misbehavior and mismanagement but good school progress; social maladjustment with adequate home and school behavior; and lastly, personality disturbances in the form of fears, desires for suicide, inferiorities, emotional and social inadequacies in spite of excellent educational progress. These are but arbitrary classifications, since there is much overlapping. Although a considerable degree of emotional tension and discord must of necessity characterize the entire group, it is the major problem of the one last mentioned.

The Stanford-Revision of the Binet, Pintner-Patterson, Porteus Maze, and Kohs Block Design tests were given as measures for determining the intellectual status, with all that that term implies. Clinically, the desire was to get a range of mental abilities rather than a composite score. Statistically, however, the purpose of this study was to determine any special values inherent in the Block Design test as compared with the others employed.

The Binet was given as the standard verbal test of intelligence. The Pintner-Patterson was utilized because it is a group of performance material involving concrete situations which demand application, concentration, judgment of physical relationships, but not dependent upon verbal concepts. The Porteus was employed

* Read at the seventh annual meeting of the American Orthopsychiatric Association, February 21–22, 1930, New York City.

TABLE I. BINET AND KOHS I.Q.; 250 CASES

Binet I.Q.	No Score	30	35	40	45	50	55	60	65	70	75	80	85	90	95	100	105	110	115	120	125	130	135	140	145	150	155	160	165	Total
145																	2			1										3
140																	1					2								3
135																														4
130														1		1	1		1											7
125	1														2			1				1			1			1		10
120													1	2		1		1		2	2		1							4
115													1		1					1	1									14
110	1								1		2	1	2	1	2	1	1	1	1	1										19
105	2								1	3		1	4	2	2	1	1		1		1									27
100	1							1	1	2	6		2	1	4	2	1	1	1	1	2	1								18
95									1	2	2	2	1	1	3	3	2			1										17
90	1							2	1	2	1	3	2	1	1	1				2										18
85	1					1	1		1	3	3	3	3	1		1														21
80					1		3		4	2		3	3	4	1															28
75	3			1		1	5	4	4	1	3	1	1	2	1		1													17
70	1		1		1	2	5	1		1		2	1	1	1															13
65	4					2	2	3		2																				7
60	4			1			1	1																						13
55	4				1	2	4		1		1																			2
50	2																													2
45	2																													3
40	2			1																										0
35																														
	29	0	1	3	3	8	21	12	14	18	18	16	21	17	16	13	10	4	4	9	6	4	0	1	1	0	0	1		250

Kohs I. Q.

r = +.63

TABLE II. BINET AND KOHS M.A.; 250 CASES

Kohs M.A.

TABLE II. BINET AND KOHS M.A.: 250 CASES

Binet M.A. \ Kohs M.A.	No Score	5–6	6	6–6	7	7–6	8	8–6	9	9–6	10	10–6	11	11–6	12	12–6	13	13–6	14	14–6	15	15–6	16	16–6	17	17–6	18	18–6	19	19–6	Total
17–6																												1			1
17																															0
16–6																														1	1
16													1			1	1		1												4
15–6														1	1		1														3
15													1								1										1
14–6												1				2			1												2
14											1																				4
13–6																1															0
13									1	1			1	1		1															5
12–6							1						2			1	1	1	1												7
12						1				1		1		3									1								7
11–6						1			2		1	1			2																7
11						1	1	1		1	1	1	1	1		1															9
10–6		3		1						1	1		1	1																	8
10					2		2	1	4	1	3	1	2							1											17
9–6	1		2		1	2	4	1	1	3		1	2	2		1															21
9			1		2	2	1	1			2	1		1																	11
8–6			2	4	5	3	2		2	1	1		1																		21
8	1	3	5	3	1		5	1	2				1																		22
7–6	2	6	5	2	1	5	2			2																					25
7	3	4	5	3	2		2	1	1																						21
6–6	8	4	3	3		1	3	1																							23
6	4	3	4		1		1																								13
5–6	3			1																											4
5	4	3																													7
4–6																															0
4	3																														3
3–6	1																														1
3	2																														2
	32	26	27	17	15	16	24	7	13	11	10	7	13	10	3	7	3	1	3	1	1	0	1	0	0	0	0	1	0	1	250

r=+.82

TABLE III. BINET AND KOHS I.Q.: 155 CASES

Binet I.Q.	No Score	35	40	45	50	55	60	65	70	75	80	85	90	95	100	105	110	115	120	125	130	135	140	145	Total
145																									
140																1			1						2
135																1					1				2
130															1	1		1							3
125															1		1							1	3
120									1			1	2		1		1		2				1		8
115												1							1	1					4
110										1	1	2	1	1	1	1	1	1	1						11
105									2+1			5	1	3	2	2		1		1					18
100							1	1	2	6		1	1	4	1		1	1	1	2	1				23
95								1	1	2	2	1	1	2	3	2			1						16
90	1						2	1	2	1	3	2	1		1				1						15
85	1					1		1	2	1	2	3	1		1										13
80						2		3	2	1	2	2	3	1											16
75	3		1		1	4	3	3	1	1	2	1	2	1	1										24
70	1				2	2	1			1	2	1													10
65	3				2	2	2		2																11
60	4						1																		5
55	4			1		2																			7
50	1																								1
45	1																								1
40	2																								2
	21	0	1	1	5	13	10	10	16	14	14	20	13	12	13	8	4	4	8	4	2	0	1	1	195

Kohs I.Q.

r=+.76

TABLE IV. PORTEUS AND KOHS I.Q.: 195 CASES

Kohs I.Q.

TABLE IV. PORTEUS AND KOHS I.Q.: 195 CASES

Porteus I.Q.	Kohs I.Q.																									
	No Score	30	35	40	45	50	55	60	65	70	75	80	85	90	95	100	105	110	115	120	125	130	135	140	145	Total
175																			1							1
170																										0
165													1													1
160																										0
155																										0
150																										0
145																									1	1
140											1								1	1	1	1				5
135																1										1
130																	2		1							3
125												1			1	3	1	1		1	1					9
120													1		1	1	1		1	2		1				7
115										1	2			3					1	2		1				10
110										2		1	1		2	3					1					10
105								1	2		1		1		4	2	2	1		1	1					16
100									1	1	2	3	3		2					1						13
95	1					1				2	1	2	2	1		1				1						12
90	1				1		1	1		3	1		3	3	3			1			1					19
85	1								2	4	2	1		1		2										13
80	1						1		1	1	1	1	2	1	1											10
75	1					1			1	2	1	1														7
70	1					2	4			1		1			1		1									11
65	1					1	2	5	1		1		2													11
60	5					1	2	3	1	1		2	1	1												17
55	1					1	2					1														5
50	4						1	1				1														7
45	2						1																			3
40	2																									2
35	1																									1
30	22	0	0	0	1	7	12	11	9	18	13	15	17	10	15	13	7	3	5	9	5	2	0	0	1	195

r=+.68

TABLE V. PERFORMANCE SERIES AND KOHS I.Q.; 195 CASES

Pintner Patterson	Kohs I.Q.																									
		No Score	30	35	40	45	50	55	60	65	70	75	80	85	90	95	100	105	110	115	120	125	130	135	140	145	Total
	165																										0
	160																									1	1
	155																										0
	150																										0
	145																				1						1
	140																		1		1						2
	135																										0
	130															1	1					1					3
	125																				1						1
	120															1		3		1		1					6
	115															1	2	1	1		2	1					8
	110											2	1	1	1	1	2			1	2	1					12
	105										2					1	1	3	1	1		1					10
	100	1						1		2	1	1		1	1	2	2	1				1					14
	95	1							1	1	2	1		2		3	2				1						14
	90	1					1		2		4	1	3	4	3		2						1				22
	85								1	1	1			4	2	3	2								1		15
	80	1					2	1		2		1	4	2	1	1					1						16
	75	4								4	2	2	3	2	1	1											19
	70	1				1		1				2	2		2												9
	65	1						6	5		4		2	1													19
	60	1					2	1	1			1		1													7
	55	2					1	2			1																6
	50	2																									2
	45							1																			1
	40	1																									1
	35																										0
	30	6																									6
		22	0	0	0	1	6	13	10	10	17	11	15	18	11	15	14	8	3	3	9	6	1	0	1	1	195

r=+.71

	22	0	0	0	1	6	13	10	10	17	11	15	18	11	15	14	8	3	3	9	6	1	0	1	1	195

r=+.71

TABLE VI. BINET AND KOHS I.Q.: BORDERLINE GROUP

Kohs I.Q.

Binet I.Q.	No Score	30	35	40	45	50	55	60	65	70	75	80	85	90	95	100	105	110	115	Total
79	1						1	1	1			1	1	1						7
78	2			1		1	2		1							1				8
77							1	1												2
76							1	1		1	1									4
75								1	2		2			1	1					7
74			1									1								2
73								1				1			1					3
72	1			1			3						1							6
71							2													2
70						2				1				1						4
	4	0	1	2	0	3	10	5	4	2	3	3	2	3	2	1				45

r=+.02

because it is also a series of tests as Porteus says, "to examine the individual's ability to use planning capacity, prudence and mental alertness in a new concrete situation." He also states that "these tests aim specifically at showing up the temperamental defects which interfere with mental ability and thus mar achievements." Hence, it is a "supplementary test useful for diagnostic purposes."

The Kohs Block Design test is a performance test calling for little verbal explanation. To quote Kohs, "it requires first the breaking up of each design presented into logical units, and second a reasoned manipulation of blocks to reconstruct the original design from these separate parts. The results of this activity, it is presumed yield a fair index of this analytic-synthetic power which we have termed 'intelligence.' It also demands an inherent color sense, and the ability to perceive accurately and form relationships."

It may be of interest to note here, that in the year 1914, Maxfield at the University of Pennsylvania, constructed a similar set of cubes. He used them in the clinic to study the imageability of children. His procedure was different from that employed in the Kohs test.

According to Kohs, his test is an adequate measure of intelligence. "If intelligence involves the following mental operations: —analyzing, combining, comparing, deliberating, completing, discriminating, judging, criticising and deciding, the block design test may be said to call upon the functioning of intelligence and to that extent they are measures of that mental capacity." His results indicate that the test assists in differentiating the feeble-minded from the borderline or normal group. And because of the high degree of correlation between the Block test and the Binet he suggests that the Block test may be substituted for the Binet and be useful, since it requires little language understanding.

The correlation between the scores of our 250 Binet and Kohs I.Q.'s is .63, P.E. $\pm$.02, as compared with Kohs .58 for his school children; .67 for his feeble-minded and .80 for the entire group. (See Table I.)

The correlation of the M.A.'s of the two tests is comparable to that obtained by Kohs, ours being .82 P. E. $\pm$.01; Kohs, .81. This discrepancy between the I.Q. and M. A. correlation is identical with that found by Kohs. (See Table II.)

Since the greatest number of cases, 195, fell between the ages

6–12 inclusive, it seemed advisable to use these for further comparisons, thus omitting a group at each end least capable on the Kohs,—those from 5–6 years, and at the upper ages including the greatest number of school retardations. The correlation between the Binet and the Kohs I.Q. of these 195 is .76 ± .02, the Binet range from 40 I.Q. to 145; Kohs from no score to 150. (See Table III.)

The correlation between the M.A.'s of this group is .64 ± .03.

The correlation between the Porteus and Kohs I.Q. is .68 (See Table IV.).

The correlation between the Pintner-Patterson and the Kohs I.Q. is .71. (See Table V.)

When we compare the scores of the upper 45 who have Binets ranging from 110 to 145 we get a correlation with the Kohs of .65, P.E. ± .06. With the same superior group the correlation between the Kohs and Porteus is .34, the Pintner-Patterson is .46. We find a higher positive correlation between the Kohs and Binet than between the Kohs and Porteus or Pintner-Patterson.

In the borderline group, Binet I.Q. 70–80, there is a correlation of +.02 with Kohs I.Q., the spread of ability on the Kohs being great. (See Table VI.) Twenty-seven or 50% fall below 70 on the Kohs and six get normal ratings, 90–105. Neither the Kohs nor the Binet, either alone or in conjunction seem to be adequate decisive measures. The contributing factors of dysgenic environmental forces, language difficulties speech defects, inferiorities imposed by continued failure, etc. must be taken into consideration when designating members of this group inferior.

The correlation between those of the lowest Binet I.Q., 40–70 and the Kohs is .23. (See Table VII.) In every instance but three the Kohs I.Q. is below the Binet. These three presented unusual problems of poor home and social environment, language handicap because of foreign language spoken in the home and also speech defect. However, their Kohs scores do not range above the dull group and indicate mental retardation.

The 50 with marked emotional disturbances present interesting findings. The correlation of the Binet I.Q. with the Kohs I.Q. is .72. (See Table VIII.). This is similar to the correlation of .76 for the entire group of 195.

The Porteus and Kohs I.Q. correlation is .54 as compared to .68 for the entire group. (See Table IX.)

TABLE VII. BINET AND KOHS I. Q.: LOWEST GROUP IN INTELLIGENCE

		Kohs I. Q.												
		No Score	30	35	40	45	50	55	60	65	70	75	80	Total
Binet I. Q.	70													
	65	4					2	2	3		2			13
	60	4			1			1	1					7
	55	4				1	2	4		1		1		13
	50	2												2
	45	2												2
	40	2			1									3
		18	0	0	2	1	4	7	4	1	2	1		40
		r=+23												

The Pintner-Patterson and Kohs I.Q. correlation is .54 as compared with .71 for entire group. (See Table X.)

A closer study of the Kohs and Binet I.Q. ratings discloses a Binet range from 65 to 145 I. Q.; Kohs from no score to 110 I. Q. Although there is a high positive correlation, there is a consistent lowering of the Kohs I. Q. throughout. This becomes decidedly marked when we study the various individuals of this disturbed group. The twenty with Binet I. Q. of 110 to 145, all have inferior Kohs scores ranging from 70 to 105, indicating no mental acceleration. However, this is in direct contrast to the school, home and Binet findings. It may be that the Kohs I.Q. is an index of their emotional instability rather than of their intellectual status. (See Table XI.)

It is recognized that emotional instability impairs the measurement of intelligence. Its effects are noted in ineffectual direction of the intelligence towards definite work and it diminishes the results attained by the application of the theoretic unit of intelligence.

All intelligence testing involves an integrated intelligence of the child which reflects its total organic state involving not merely emotional conditioning, but past habits of procedure, conscious and unconscious attitudes of minds, and elements of behavior which have conditioned past performances and also the mode of attack upon a new situation.

The Kohs test depends upon an analysis and synthesis relationship. Our results would appear to indicate that these mental

TABLE VIII. BINET AND KOHS I.Q.; EMOTIONALLY DISTURBED

Binet I.Q.	Kohs I.Q.																			
	No Score	30	35	40	45	50	55	60	65	70	75	80	85	90	95	100	105	110	115	Total
145																	1			1
140																	1			1
135																1	1			2
130																1				1
125												1	1	2		1				5
120													1		1					2
115										1	2	1	1		2		1			8
110										4			1		1					7
105	1								1	1	1									3
100							1		1	1	1									4
95								2				2	1							6
90	1					1	1		1					1						2
85	1							1	1											4
80			1				1													2
75																				1
70																				1
65	1																			
	4	0	1	0	0	1	3	3	4	7	4	4	5	3	4	3	4			50

r = +.72

TABLE IX. PORTEUS AND KOHS I.Q.; EMOTIONALLY DISTURBED

Porteus I.Q.	Kohs I.Q. No Score	30	35	40	45	50	55	60	65	70	75	80	85	90	95	100	105	110	115	Total
140																				1
135													1							0
130																	2			2
125																1				1
120																				0
115										1	1			3			1			5
110										1										2
105							1	1	1		1		1		1	1	1			8
100									1	1		3	1		1	1				7
95	1									1	1					1				4
90								1		1					1					2
85									1											1
80									1	1					1					3
75							2		1											1
70													1							2
65						1		1		1		1	1							3
60	2		1								1									6
55																				1
50																				0
45																				0
40	1																			1
35																				0
30																				
	4	0	1	0	0	1	3	3	4	7	4	4	5	3	4	3	4			50

$r = +.54$

TABLE X. PERFORMANCE SERIES AND KOHS I.Q.: EMOTIONALLY DISTURBED

Pintner Patterson I. Q.	Kohs I. Q.																			
	No Score	30	35	40	45	50	55	60	65	70	75	80	85	90	95	100	105	110	115	Total
125																	1			1
120																				0
115											1									1
110																	3			3
105																				5
100							1			1			1	1	1	1				5
95	1									2	1	1	1	2		1				9
90	1							1		2	1	1			1	1				1
85															1					3
80									1				1		1					8
75	1								3		2		1		1					2
70												2								6
65							2	1		3										2
60								1					1							1
55										1										0
50						1														1
45																				1
40	1																			1
35			1																	0
30																				
	4	0	1	0	0	1	3	3	4	7	4	4	5	3	4	3	4			50

r = +.54

processes in relationship may be more upset by emotions than our ordinary habits of mind. There is little reason to believe that the mental habits or conditioning behavior of the child towards the examiner, or the attitudes of the child towards the test, or the emotions underlying his difficulties are particularly altered in approaching the Kohs test as compared with the Binet, the Porteus or the Pintner-Patterson series of tests. It is doubtful whether the Kohs test situation is likely to call forth greater emotional stress or disturbance. None the less the results of the Kohs test with the children with emotional disturbances evidence more

TABLE XI. BINET AND KOHS I.Q.: 20 CASES. EMOTIONALLY DISTURBED

		Kohs I. Q.												
		No Score	65	70	75	80	85	90	95	100	105	110	115	Total
Binet I. Q.	145													
	140										1			1
	135										1			1
	130									1	1			2
	125									1				1
	120					1	1	2		1				5
	115						1		1					2
	110			1	2	1	1		2		1			8
				1	2	2	3	2	3	3	4			20

marked influence of the underlying emotions. The inequalities in results of this variety of tests as well as the scattering performances upon any single test are useful in revealing underlying emotional difficulties.

The Kohs test presents a more complex problem of solution than does the Porteus test. There is a great necessity for analysis before synthesis can be undertaken. The Porteus Maze apparently requires less grasp of the problem as a whole than does the Kohs test as the examinee can proceed slowly along the colorless lines, analyzing step by step in the course of drawing the line requisite for solution.

In the Pintner-Patterson series such a test, for example, as that of the Mare and Foal adds values that are not inherent in the Kohs test by reason of the relationships of form or color or both with relations more or less suggested and delimited by clean cut contactual margins. On the Stanford Binet test there is nothing

similar to the problems raised by the Kohs test. (The emotional interference is well illustrated, for example in the differences in the correlations of the emotional and non-emotional group for the Binet and Kohs, Kohs and Porteus and Pintner-Patterson and Kohs).

To sum up:

1. From a psycho-clinical point of view the Kohs test offers definite supplementary evidence when dealing with the feeble-minded.

2. According to our findings it does not differentiate the borderline group. The results are lower than the Binet when the emotionally disturbed group is considered.

3. Although there is a fairly high correlation with the Binet, it should not be substituted for it.

4. The Kohs test offers information of special value when it is employed in the study of individual problems of personality.

5. The Kohs test appears sensitive to emotional interferences with intellectual effectiveness.

NOTES AND COMMENTS

All titles and abstracts of papers for consideration by the Program Committee of the American Orthopsychiatric Association, for the 1931 meeting, should be mailed to the Secretary, Dr. George S. Stevenson, National Committee for Mental Hygiene, 370 Seventh Avenue, New York City, not later than December 5th, 1930.

Dr. H. W. Newell is leaving the clinic which he has been directing under the State Board of Public Welfare in Virginia, to become the psychiatrist in the public school systems in Cleveland.

Dr. P. J. Ewerhardt becomes the Director of the newly organized clinic in Washington, which leaves a vacancy in Providence.

Dr. R. C. A. Jaenike, having completed his fellowship at the Institute for Child Guidance, becomes the assistant psychiatrist with Dr. E. K. Clarke at Rochester University.

Dr. William Ferguson has assumed the Directorship of the new clinic at Niagara Falls.

Dr. A. T. Childers, who has been for the past year the psychiatrist at the Juvenile Court in Cleveland, has assumed duty as psychiatrist for the latest project of the Couzens Fund in Detroit. It is hoped that a further statement of their plans can be made in an early issue of the JOURNAL.

While details are unavailable at present, it is understood that there has been a reorganization of the Department of Psychiatry at the University of Cincinnati, with Dr. E. A. North at the head. Here again it is the hope that further details may be later available.

The Board of the Brooklyn Home for Blind, Crippled and Defective Children, which operates the St. Charles Hospital in Brooklyn and the Port Jefferson Home for the Care and Training of Mental Defectives, at which a new building was recently dedicated, has organized a mental hygiene clinic under the direction of Dr. M. A. R. Hennessy, formerly a fellow at the Institute for Child Guidance.

A number of important developments with respect to psychiatric education, fellowships, and so on, really deserve discussion. At the present moment not enough information is at hand to do more than indicate that these are very live topics and request that those who have had particular contact with such problems should send in a short but interesting comment on this or any other issues which seem to be of importance. As announced elsewhere, the JOURNAL will appear on the 15th of October, June, April and July. Book reviews and items for Notes and Comments should reach the Editor by the first of September, December, March and June, in order to insure proper make-up of the magazine.